Data Collection and Analysis for Generating
Procedure-Specific Practice Cost Estimates
HCFA Contract No. 500-95-0009

CPEP Recorders' Notes Files

DRAFT

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CPEP RECORDERS' NOTES

This document contains information which provides context for the data in the CPEP database files. Such information could not be reflected *per se* in the data, and is intended to support subsequent review and adjustments by HCFA. *This document is a cornerstone for obtaining a complete understanding of the data files as well as for performing any adjustments to the data.*

The notes are specific to each CPEP and are structured in three categories:

- *CPEP-level notes* describe specific conventions or formulae adopted by the CPEP. For example, the notes may indicate that a CPEP used the number of post-operative visits in a formula to generate staff times for post-surgical office visits for all of its 90 day global codes.

- *Family-level notes* provide similar information that applies only to that specific family of services.

- *Service-specific notes* provide a variety of explanatory information. For example:

  - Notes are present if the data in the data files may seem inconsistent or inaccurate when taken at face value. For example, notes are present when a panel provided an estimate that is in conflict with the global period status code contained in the Medicare Fee Schedule (such as treating a 90 day global service as a ZZZ code).

  - Notes are also present when there is an unresolved Medicare policy issue that affects the inclusion/exclusion of resources in the estimates. If there are resources in question, the note contains information about the resources, so that HCFA can, at its discretion, either remove estimates that are included in the data files, or add estimates that are not included in the files.

This document is intended for users familiar with the CPEP process. Familiarity with the *Users' Guide for the Direct CPEP Practice Cost Database* and the report on the *Clinical Practice Expert Panel (CPEP) Direct Cost Estimation* is necessary for proper interpretation of the information contained in this document.

CPEP 1: Integumentary

Notes for CPEP C 1

CPEP-Level Notes

All in-office procedure-specific equipment usage is based on the longest time of a clinical staff type in the procedure (G1) period, except where noted otherwise.

1 Where out of office time occurs in the G1, it is for phone calls being made from the physician office for the following families:
104
108
112 (except codes 17304, 17305, 17306, 17307,17310)
116
120
124
128
808

For all other families of codes where out of office time occurs in the G1 it is when the staff accompanies the physician to the hospital.

2 Times were generally either profiled using the reference service originally assigned to family in which the codes exist or profiled from scratch as absolute values. Exceptions are noted below where indicated by the panel.

3 "Equipment trays" were developed and assigned to specific codes. Please see attached appendix for list of equipment contained in each of the equipment groupings.

4 For some 000 and 010 day global period services, the panel included a G0 visit.

Family 100 Nail Procedures

Family-Level Notes

1 G1X times are extrapolated from reference service 17000 G1X IN setting for both the IN and OUT settings

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 100

Family 104 Simple Debridement, Excision and Destruction

Family-Level Notes

No family-level notes for family 104

Procedure-Specific Notes

17200 Electrocautery of skin tags Panel reported zero post op. visits

Family 108 Simple Excision and Biopsy

Family-Level Notes

No family-level notes for family 108

Procedure-Specific Notes

15860	*Test for blood flow in graft*	Panel determined that this is a physician work component only. Panel costed this as zero clinical and administrative staff time.

Family 112 Complex Excision and Debridement

Family-Level Notes

No family-level notes for family 112

Procedure-Specific Notes

16035	*Incision of burn scab*	Panel reported zero post op. visits.
17304	*Chemosurgery of skin lesion*	These are Mohs surgery codes. Panel reported that in the out of office setting a skilled Mohs surgery nurse must accompany the physician in order to perform the procedure. The equipment exception time formula for code There are 2 nurses involved in the Intra period Formula = G1 RN pre + G1 RN post + 1/2 G1 RN intra
17305	*2nd stage chemosurgery*	Code represents add on procedure for additional specimens which does not incur additional administrative time. The equipment exception time formula for code There are 2 nurses involved in the Intra period Formula = G1 RN pre + G1 RN post + 1/2 G1 RN intra
17306	*3rd stage chemosurgery*	Code represents add on procedure for additional specimens which does not incur additional administrative time. The equipment exception time formula for code There are 2 nurses involved in the Intra period Formula = G1 RN pre + G1 RN post + 1/2 G1 RN intra
17307	*Followup skin lesion therapy*	Code represents add on procedure for additional specimens which does not incur additional administrative time. The equipment exception time formula for code There are 2 nurses involved in the Intra period Formula = G1 RN pre + G1 RN post + 1/2 G1 RN intra
17310	*Extensive skin chemosurgery*	Code represents add on procedure for additional specimens which does not incur additional administrative time. The equipment exception time formula for code There are 2 nurses involved in the Intra period Formula = G1 RN pre + G1 RN post + 1/2 G1 RN intra

Family 116 Dermabrasion and Cryotherapy

Family-Level Notes

1 G1X times are profiled from reference service 12002 G1X IN setting for both the IN and OUT settings. The G2 and G2X times for both sites of service for this family were also taken from 12002.

Procedure-Specific Notes

17340	*Cryotherapy of skin*	Panel reported zero post op. visits.

Family 120 Incision and Drainage

Family-Level Notes

1 The G0 times recorded for the out of office setting were taken from G1 of the Reference service 99243.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 120

Family 124 Simple Skin Repair

Family-Level Notes

No family-level notes for family 124

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 124

Family 128 Complex Skin Repairs Including Integument Grafts, Transfer and Rearrangement

Family-Level Notes

1 The panel used the Hsiao intra times as the driver for profiling the G1 in office intra portion of the codes.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 128

Family 132 Photochemotherapy

Family-Level Notes

No family-level notes for family 132

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 132

Family 136 Occupational Therapy

Family-Level Notes

1 The staff time is primarily for pre and post activities.

2 When the code is clearly defined as being for an additional area of the body, or an additional period of time after the initial code's tasks or time have been completed, there is no clinical or administrative staff time since it is only the G1 intra period that is affected.

3 The equipment exception time formula for codes in family:

Formula = G1 pre +G1 post + estimate of intra*
*estimate of intra is based on procedure time as defined by code description or, when not available, pattern of initial and subsequent code description in CPT i.e. 30 minutes for codes described as initial code and 15 minutes for codes described as subsequent code.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 136

Family 140 Physical Therapy

Family-Level Notes

1 The staff time is primarily for pre and post activities.

2 When the code is clearly defined as being for an additional area of the body, or an additional period of time after the initial code's tasks or time have been completed, there is no clinical or administrative staff time since it is only the G1 intra period that is affected.

3 The equipment exception time formula for codes in family unless otherwise noted at the code level:

Formula = G1 pre +G1 post + estimate of intra*
*estimate of intra is based on procedure time as defined by code description or, when not available, pattern of initial and subsequent code description in CPT i.e. 30 minutes for codes described as initial code and 15 minutes for codes described as subsequent code.

Procedure-Specific Notes

98925	*Osteopathic manipulation*	The equipment exception time formula for this code: Formula = G1 pre+G1 post + Hsiao Intra
98926	*Osteopathic manipulation*	The equipment exception time formula for this code: Formula = G1 pre+G1 post + Hsiao Intra
98927	*Osteopathic manipulation*	The equipment exception time formula for this code: Formula = G1 pre+G1 post + Hsiao Intra
98928	*Osteopathic manipulation*	The equipment exception time formula for this code: Formula = G1 pre+G1 post + Hsiao Intra
98929	*Osteopathic manipulation*	The equipment exception time formula for this code: Formula = G1 pre+G1 post + Hsiao Intra

Family 144 Muscle Strength and Range of Motion Testin

Family-Level Notes

1 The staff time is primarily for pre and post activities.

2 When the code is clearly defined as being for an additional area of the body, or an additional period of time after the initial code's tasks or time have been completed, there is no clinical or administrative staff time since it is only the G1 intra period that is affected.

3 The equipment exception time formula for codes in family unless otherwise noted at the code level:

Formula = G1 pre +G1 post + estimate of intra*
*estimate of intra is based on procedure time as defined by code description or, when not available, pattern of initial and subsequent code description in CPT i.e. 30 minutes for codes described as initial code and 15 minutes for codes described as subsequent code.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 144

Family 700 Office Visits - New Patient

Family-Level Notes

No family-level notes for family 700

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 700

Family 704 Office Visits - Established Patient

Family-Level Notes

No family-level notes for family 704

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 704

Family 728 Consultation - Office

Family-Level Notes

No family-level notes for family 728

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 728

Family 744 Nursing Facility Care, Subsequent

Family-Level Notes

No family-level notes for family 744

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 744

Family 808 Breast Procedures

Family-Level Notes

1 Reference service 12002 IN was used for the clinical base times from which to profile the in office setting for codes in this family.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 808

Summary of "Equipment Tray" Composition

ID : E30003 Soft Tissue Tray (Basic)

Total Price : $1.047 **Used by CPEP(s):** C 1

Components	*Price*
Adkins smooth	N/A
Adkins with teeth	N/A
Bishops	N/A
Blade holder	N/A
Browns forcep	N/A
Castro holder	N/A
Iris curved scissors	N/A
Iris straight scissors	N/A
Mayo curved scissors	N/A
Mayo straight scissors	N/A
Mesquito hemostats - 2	N/A
Regular hemostats - 2	N/A
Skin hooks - 2	N/A
Skin retractors	N/A
Small plastics needle holder	N/A
Towel clips	N/A

CPEP 2:
Male Genital &
Urinary

Notes for CPEP C 2

CPEP-Level Notes

All in-office procedure-specific equipment usage is based on the longest time of a clinical staff type in the procedure (G1) period, except where noted otherwise.

1 The total G1 out-of-office nurse (RN) times recorded for the codes in each of the families in CPEP 2 are categorized into two groups: 1) G1 times that are based on post-procedure functions only; and 2) G1 times that are based on the premise that the practice/office RN accompanies the physician to the out-of-office setting. Therefore, in the latter case, the G1 out-of-office times reflect time spent on pre-, intra-, and post-service functions. As described by the panel, post-procedure functions consist of responding to calls from the patient and his/her relatives. For most of the families of codes in CPEP 2, the total G1 out-of-office times denotes the time that the practice/office RN spends on these post-procedure phone calls only. The number of phone calls that the practice receives from the patient increases with the complexity of the procedure; thus, the more complex families of codes require more RN time. The categorization of families according to the basis of G1 out-of-office times is reflected in the family level notes.

There are 5 families of codes whose G1 out-of-office times are based on the assumption that the practice/office RN accompanies the physician to the out-of-office setting. According to the panel, the codes in the families require a practice/office RN to assist the physician in providing these procedures out of the office.

As defined at the outset of the CPEPs, resource requirements for pre-procedure (G0) and post-procedure (G1.X) visits, which are done in the office, are anchored according to the site-of-service of the procedure. Therefore, the out-of-office resource profiles for procedures done out of the office consist of the disposable supplies used during the pre- and post-procedure visits. These profiles do not include supplies used during the procedure itself, as these supplies would be provided by the hospital or other facility. According to the panel, the only equipment with a cost greater than $500 that is used during these visits is an exam table, which was categorized as overhead equipment.

2 "Equipment trays" were developed and assigned to specific codes. Please see attached appendix for list of equipment contained in each of the equipment groupings.

3 For some 000 and 010 day global period services, the panel included a G0 visit.

Family 200 Simple Urethral Procedures

Family-Level Notes

1 The total G1 out-of-office clinical staff time is based on the time the practice RN spends on patient calls in the post-procedure period.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 200

Family 204 Complex Urethral Procedures

Family-Level Notes

1 The total G1 out-of-office clinical staff time is based on the time the practice RN spends on patient calls in the post-procedure period.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 204

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Family 208 Urethral Catherization and Dilation -Simple

Family-Level Notes

1 The total G1 out-of-office clinical staff time is based on the time the practice RN spends on patient calls in the post-procedure period.

Procedure-Specific Notes

G0002	*Temporary urinary catheter*	The panel indicated that HCPCS code G0002 does not require any clinical staff time. Therefore, the G1 in-office time for this code is equal to 0.

Family 212 Urethral Catherization and Dilation - Complex

Family-Level Notes

1 The total G1 out-of-office time is based on the RN accompanying the physician to the out-of-office setting and assisting with the procedure.

Procedure-Specific Notes

51010	*Drainage of bladder*	Based on the information provided by the panel, the post-procedure visits (G2.X) for HCPCS code 51010 do not require administrative staff time.

Family 216 Major Transurethral Procedure

Family-Level Notes

1 The total G1 out-of-office clinical staff time is based on the time the practice RN spends on patient calls in the post-procedure period.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 216

Family 220 Testicular and Epididymal Procedures

Family-Level Notes

1 The total G1 out-of-office clinical staff time is based on the time the practice RN spends on patient calls in the post-procedure period.

Procedure-Specific Notes

76942	*Echo guide for biopsy*	According to the panel, there is no administrative staff time associated with this code when it is done out of the office.

Family 224 Simple Penile Procedures

Family-Level Notes

1 The total G1 out-of-office clinical staff time is based on the time the practice RN spends on patient calls in the post-procedure period.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 224

Family 228 Complex Penile Procedures

Family-Level Notes

1 The total G1 out-of-office clinical staff time is based on the time the practice RN spends on patient calls in the post-procedure period.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 228

Family 232 Insertion of Penile Prosthesis

Family-Level Notes

1 The total G1 out-of-office clinical staff time is based on the time the practice RN spends on patient calls in the post-procedure period.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 232

Family 236 Urinary Tract Biopsy

Family-Level Notes

1 The total G1 out-of-office time is based on the RN accompanying the physician to the out-of-office setting and assisting with the procedure.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 236

Family 244 Simple Cystourethroscopy

Family-Level Notes

1 The total G1 out-of-office time is based on the RN accompanying the physician to the out-of-office setting and assisting with the procedure.

Procedure-Specific Notes

G0025 Collagen skin test kit	The panel indicated that HCPCS code G0025 does not require any clinical staff time. Therefore, the G1 in-office time for this code is equal to 0.

Family 248 Moderate Cystourethroscopy

Family-Level Notes

1 The total G1 out-of-office time is based on the RN accompanying the physician to the out-of-office setting and assisting with the procedure.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 248

Family 256 Motility Studies

Family-Level Notes

1 The total G1 out-of-office clinical staff time is based on the time the practice RN spends on patient calls in the post-procedure period.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 256

Family 260 Major Procedure - Renal

Family-Level Notes

1 The total G1 out-of-office clinical staff time is based on the time the practice RN spends on patient calls in the post-procedure period.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 260

Family 264 Major Procedure -Urinary tract except kidney

Family-Level Notes

1 The total G1 out-of-office clinical staff time is based on the time the practice RN spends on patient calls in the post-procedure period.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 264

Family 268 Nephrostomy, Complex Cystourethroscopy, and Litholapaxy

Family-Level Notes

1 The total G1 out-of-office time is based on the RN accompanying the physician to the out-of-office setting and assisting with the procedure.

Procedure-Specific Notes

52317	*Remove bladder stone*	This code was originally classified as an out-of-office procedure based on 1994 Medicare volume data. However, the panel agreed that the site-of-service for this code should also include the in-office setting because it is performed in the office at least 10% of the time by large practices. The provision of this procedure requires the use of a very costly piece of equipment, the lithotriptor. While the "typical" practice would not be equipped with a lithotriptor, the larger practices that are providing this service would have a lithotriptor in their office. Therefore, as agreed upon by the panel, the lithotriptor was included in the in-office resource profile to reflect the practice costs of the larger practices that are billing these services.
74475	*Xray control catheter insert*	According to the panel, there is no administrative staff time associated with this code when it is done out of the office.
74480	*Xray control catheter insert*	According to the panel, there is no administrative staff time associated with this code when it is done out of the office.
74485	*X-ray guide, GU dilation*	According to the panel, there is no administrative staff time associated with this code when it is done out of the office.

Family 272 Renal Extracorporeal Shock Wave Lithotripsy

Family-Level Notes

1 The total G1 out-of-office clinical staff time is based on the time the practice RN spends on patient calls in the post-procedure period.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 272

Family 452 Hysterectomy - Urology

Family-Level Notes

1 The total G1 out-of-office clinical staff time is based on the time the practice RN spends on patient calls in the post-procedure period.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 452

Family 704 Office Visits - Established Patient

Family-Level Notes

No family-level notes for family 704

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 704

Family 724 Consultation - Inpatient

Family-Level Notes

1 The G1 out-of-office nurse (RN) times for the codes in this family represent the time that a practice/office RN allocates to compiling patient charts/reviewing medical history in preparation for these consultations.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 724

Family 728 Consultation - Office

Family-Level Notes

1 The G1 out-of-office nurse (RN) times for the codes in this family represent the time that a practice/office RN allocates to compiling patient charts/reviewing medical history in preparation for these consultations.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 728

ID : E30020 Minor Surgical Tray

Total Price : $572 **Used by CPEP(s):** C 2

Components	*Price*
1oz shot glasses	N/A
Adson forceps	N/A
Allis clamp	N/A
Army navy retractor	N/A
Cutting stat	N/A
Foreps	N/A
Hemostat	N/A
Knife handle	N/A
Light source	N/A
Metzenbaum scissors	N/A
Needle driver	N/A
Senn retractor	N/A
Skin hooks	N/A
Suture scissors	N/A
Tray	N/A
Weitlanner retractor	N/A

CPEP 3: Orthopaedics

Notes for CPEP C 3

CPEP-Level Notes

All in-office procedure-specific equipment usage is based on the longest time of a clinical staff type in the procedure (G1) period, except where noted otherwise.

1 Panel used a general rule for costing all codes, except those in the E&M families. All codes were profiled from a reference service, with changes indicated for length of stay in hospital, and the number of post-op visits when appropriate. These were the two drivers for this CPEP. The length of stay driver applied only to out-of-office situations, where the panel stated that all clinical service time (G1) consisted of phone calls. This phone call time varied by ten minutes for each day added to the length of stay from the reference service for each particular family. In-office there was no length of stay adjustment. The post-op visit driver applied to both sites. The panel adjusted G2 insurance/billing staff time by five minutes for each change in the number of post-op visits from the reference service.

2 "Equipment trays" were developed and assigned to specific codes. Please see attached appendix for lists of equipment contained in each of these equipment groupings.

3 For some 000 and 010 day global period services, the panel included a G0 visit.

Family 140 Physical Therapy

Family-Level Notes

No family-level notes for family 140

Procedure-Specific Notes

97701	*Supplemental checkout*	Panel decided that this code required no administrative time.
M0005	*Off visit 2/more modalities*	Panel decided that this code required no administrative time.
M0006	*One phys therapy modality*	Panel decided that this code required no administrative time.
M0007	*Combined phys ther mod & tx*	Panel decided that this code required no administrative time.
M0008	*Combined phys ther mod & tx*	Panel decided that this code required no administrative time.

Family 300 Hip Fracture Repair

Family-Level Notes

No family-level notes for family 300

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 300

Family 304 Orthopaedics - Hip Procedures (except hip replacement or hip fracture repair)

Family-Level Notes

No family-level notes for family 304

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 304

Family 308 Hip Replacement

Family-Level Notes

No family-level notes for family 308

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 308

Family 312 Knee Replacement

Family-Level Notes

No family-level notes for family 312

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 312

Family 316 Orthopaedics - Knee Joint and Surrounding Structures (except knee replacement)

Family-Level Notes

No family-level notes for family 316

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 316

Family 320 Orthopaedics - Foot

Family-Level Notes

1 Equipment Exception Time - All codes in this family that have equipment used a foot and ankle surgery pack in the office. The G1 time provided by the panel included time for two nurses during the procedure, but the equipment is only used for the actual time of the procedure. All codes had the same service time of 170 min (RN), 60 minutes of which was G1 intra service time of 2 RNs. Therefore, (after removing 30 min for the second nurse during the procedure), a total time of 140 minutes was used as equipment time for all codes.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 320

Family 324 Orthopaedics - Lower Leg/Ankle

Family-Level Notes

No family-level notes for family 324

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 324

Family 328 Orthopaedics - Lower Leg

Family-Level Notes

No family-level notes for family 328

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 328

Family 332 Orthopaedics - Thigh

Family-Level Notes

No family-level notes for family 332

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 332

Family 336 Orthopaedics - Hand

Family-Level Notes

1 Panel divided this family into several smaller groups, including: replant, open wound, non-functional, multiple graft, and functional codes. Within these groups, post-op visit profiles varied based on the panel designating a code as "medium" or "big" in terms of complexity. "Medium" codes had 10 more minutes of RN time during post-op visits compared to the reference service (not including changes in number of post-op visits). "Big" codes had 30 more minutes of RN time during post-op visits than "medium" codes (i.e., 40 minutes more than the reference service).

2 Panel indicated that codes without G0 time in this family were emergent situations.

Procedure-Specific Notes

25927 *Amputation of hand* — Code classified as big.

25931 *Amputation follow-up surgery* — Code classified as big.

26040 *Release palm contracture* — Code classified as medium.

26045 *Release palm contracture* — Code classified as medium.

26105 *Biopsy finger joint lining* — Code classified as medium.

26110 *Biopsy finger joint lining* — Code classified as medium.

26116 *Removal of hand lesion* — Code classified as medium.

26117 *Remove tumor, hand/finger* — Code classified as medium.

26121 *Release palm contracture* — Code classified as big.

26123 *Release palm contracture* — Code classified as big.

26125 *Release palm contracture* — This is a ZZZ code. The panel consistently profiled other ZZZ codes with zero or minimal G2 administrative time and no G0 or post-op visits. However, the panel inadvertently assigned G0, G1.X, G2, and G2.X time to this service. To be consistent with the profiling of other ZZZ codes by this panel, this time is not reflected in the data but is detailed below:

G0 57 min RN, 5 min Receptionist
G1.X 247 min RN (5 post-op visits)
G2 65 min Med Sec, 5 min Receptionist, 77 min Ins/Billing, 10 min Transcriptionist
G2.X 25 min Med Sec, 65 min Receptionist, 50 min Transcriptionist, 50 min RN

Supplies are also required for the G0 and post-op visits. These supplies are not reflected in the data but are detailed below:

exam table paper	42 ft.
pillow case	6
patient gown	6
gloves, non-sterile	12 pair

Code classified as big.

26140 *Revise finger joint, each* — Code classified as medium.

26145 *Tendon excision, palm/finger* — Code classified as medium.

26200 *Remove hand bone lesion* — Code classified as medium.

Family '36 (continued)

26205	*Remove/graft bone lesion*	Code classified as big.
26215	*Remove/graft finger lesion*	Code classified as big.
26250	*Extensive hand surgery*	Code classified as medium.
26255	*Extensive hand surgery*	Code classified as big.
26260	*Extensive finger surgery*	Code classified as medium.
26261	*Extensive finger surgery*	Code classified as big.
26262	*Partial removal of finger*	Code classified as medium.
26320	*Removal of implant from hand*	Code classified as medium.
26350	*Repair finger/hand tendon*	Code classified as big.
26352	*Repair/graft hand tendon*	Code classified as big.
26356	*Repair finger/hand tendon*	Code classified as big.
26357	*Repair finger/hand tendon*	Code classified as big.
26358	*Repair/graft hand tendon*	Code classified as big.
26370	*Repair finger/hand tendon*	Code classified as big.
26372	*Repair/graft hand tendon*	Code classified as big.
26373	*Repair finger/hand tendon*	Code classified as big.
26390	*Revise hand/finger tendon*	Code classified as medium.
26392	*Repair/graft hand tendon*	Code classified as big.
26410	*Repair hand tendon*	Code classified as medium.
26412	*Repair/graft hand tendon*	Code classified as medium.
26415	*Excision, hand/finger tendon*	Code classified as medium.
26416	*Graft hand or finger tendon*	Code classified as medium.
26418	*Repair finger tendon*	Code classified as medium.
26420	*Repair/graft finger tendon*	Code classified as medium.
26426	*Repair finger/hand tendon*	Code classified as medium.
26428	*Repair/graft finger tendon*	Code classified as medium.
26432	*Repair finger tendon*	Code classified as medium.
26433	*Repair finger tendon*	Code classified as medium.
26434	*Repair/graft finger tendon*	Code classified as medium.

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Family 336 (continued)

26437	*Realignment of tendons*	Code classified as medium.
26440	*Release palm/finger tendon*	Code classified as big.
26442	*Release palm & finger tendon*	Code classified as big.
26445	*Release hand/finger tendon*	Code classified as big.
26449	*Release forearm/hand tendon*	Code classified as big.
26471	*Fusion of finger tendons*	Code classified as medium.
26474	*Fusion of finger tendons*	Code classified as medium.
26476	*Tendon lengthening*	Code classified as medium.
26477	*Tendon shortening*	Code classified as medium.
26478	*Lengthening of hand tendon*	Code classified as medium.
26479	*Shortening of hand tendon*	Code classified as medium.
26480	*Transplant hand tendon*	Code classified as big.
26483	*Transplant/graft hand tendon*	Code classified as big.
26485	*Transplant palm tendon*	Code classified as big.
26489	*Transplant/graft palm tendon*	Code classified as big.
26490	*Revise thumb tendon*	Code classified as medium.
26492	*Tendon transfer with graft*	Code classified as medium.
26494	*Hand tendon/muscle transfer*	Code classified as medium.
26496	*Revise thumb tendon*	Code classified as medium.
26497	*Finger tendon transfer*	Code classified as medium.
26498	*Finger tendon transfer*	Code classified as medium.
26499	*Revision of finger*	Code classified as medium.
26500	*Hand tendon reconstruction*	Code classified as medium.
26502	*Hand tendon reconstruction*	Code classified as medium.
26504	*Hand tendon reconstruction*	Code classified as medium.
26508	*Release thumb contracture*	Code classified as medium.
26510	*Thumb tendon transfer*	Code classified as medium.
26516	*Fusion of knuckle joint*	Code classified as medium.

Family 336 (continued)

26517	*Fusion of knuckle joints*	Code classified as medium.
26518	*Fusion of knuckle joints*	Code classified as medium.
26520	*Release knuckle contracture*	Code classified as medium.
26525	*Release finger contracture*	Code classified as medium.
26530	*Revise knuckle joint*	Code classified as medium.
26531	*Revise knuckle with implant*	Code classified as medium.
26535	*Revise finger joint*	Code classified as medium.
26536	*Revise/implant finger joint*	Code classified as medium.
26540	*Repair hand joint*	Code classified as medium.
26541	*Repair hand joint with graft*	Code classified as medium.
26542	*Repair hand joint with graft*	Code classified as medium.
26545	*Reconstruct finger joint*	Code classified as medium.
26548	*Reconstruct finger joint*	Code classified as medium.
26550	*Construct thumb replacement*	Code classified as big.
26552	*Construct thumb replacement*	Code classified as big.
26555	*Positional change of finger*	Code classified as big.
26557	*Construct finger replacement*	Code classified as big.
26558	*Added finger surgery*	Code classified as big.
26559	*Added finger surgery*	Code classified as big.
26560	*Repair of web finger*	Code classified as medium.
26561	*Repair of web finger*	Code classified as medium.
26562	*Repair of web finger*	Code classified as medium.
26565	*Correct metacarpal flaw*	Code classified as medium.
26567	*Correct finger deformity*	Code classified as medium.
26568	*Lengthen metacarpal/finger*	Code classified as big.
26580	*Repair hand deformity*	Code classified as medium.
26585	*Repair finger deformity*	Code classified as medium.
26587	*Reconstruct extra finger*	Code classified as medium.

 DRAFT

Family 336 (continued)

26590	*Repair finger deformity*	Code classified as medium.
26591	*Repair muscles of hand*	Code classified as medium.
26593	*Release muscles of hand*	Code classified as medium.
26597	*Release of scar contracture*	Code classified as medium.
26820	*Thumb fusion with graft*	Code classified as big.
26841	*Fusion of thumb*	Code classified as medium.
26842	*Thumb fusion with graft*	Code classified as big.
26843	*Fusion of hand joint*	Code classified as medium.
26844	*Fusion/graft of hand joint*	Code classified as big.
26850	*Fusion of knuckle*	Code classified as medium.
26852	*Fusion of knuckle with graft*	Code classified as big.
26860	*Fusion of finger joint*	Code classified as medium.
26861	*Fusion of finger joint, added*	This is a ZZZ code. The panel consistently profiled other ZZZ codes with zero or minimal G2 administrative time and no G0 or post-op visits. However, the panel inadvertently assigned G0, G1.X, G2, and G2.X time to this service. To be consistent with the profiling of other ZZZ codes by this panel, this time is not reflected in the data but is detailed below: G0 57 min RN, 5 min Receptionist G1.X 247 min RN (5 post-op visits) G2 65 min Med Sec, 5 min Receptionist, 77 min Ins/Billing, 10 min Transcriptionist G2.X 25 min Med Sec, 65 min Receptionist, 50 min Transcriptionist, 50 min RN Supplies are also required for the G0 and post-op visits. These supplies are not reflected in the data but are detailed below: exam table paper 42 ft. pillow case 6 patient gown 6 gloves, non-sterile 12 pair Code classified as medium.
26862	*Fusion/graft of finger joint*	Code classified as big.

 DRAFT

Family 336 (continued)

26863 *Fuse/graft added joint*

This is a ZZZ code. The panel consistently profiled other ZZZ codes with zero or minimal G2 administrative time and no G0 or post-op visits. However, the panel inadvertently assigned G0, G1.X, G2, and G2.X time to this service. To be consistent with the profiling of other ZZZ codes by this panel, this time is not reflected in the data but is detailed below:

G0 57 min RN, 5 min Receptionist
G1.X 247 min RN (5 post-op visits)
G2 65 min Med Sec, 5 min Receptionist, 77 min Ins/Billing, 10 min Transcriptionist
G2.X 25 min Med Sec, 65 min Receptionist, 50 min Transcriptionist, 50 min RN

Supplies are also required for the G0 and post-op visits. These supplies are not reflected in the data but are detailed below:

exam table paper	42 ft.
pillow case	6
patient gown	6
gloves, non-sterile	12 pair

Code classified as big.

26910 *Amputate metacarpal bone* Code classified as medium.

26951 *Amputation of finger/thumb* Code classified as medium.

26952 *Amputation of finger/thumb* Code classified as medium.

Family 340 Orthopaedics - Wrist Joint and Surrounding Structures

Family-Level Notes

1 Panel divided this family into smaller groups, including non-functional, bone, and functional codes. These groups did not systematically affect the costing of the codes.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 340

Family 344 Orthopaedics - Forearm

Family-Level Notes

1 Panel divided this family into several smaller groups, including: replant, open wound, non-functional, multiple bone, and functional codes. Within these groups, post-op visit profiles varied based on the panel designating a code as "medium" or "big" in terms of complexity. "Medium" codes had 10 more minutes of RN time during post-op visits compared to the reference service (not including changes in number of post-op visits). "Big" codes had 30 more minutes of RN time during post-op visits than "medium" codes.

Procedure-Specific Notes

24495 *Decompression of forearm* Code classified as big.

24635 *Repair elbow fracture* Code classified as big.

25020 *Decompression of forearm* Code classified as big.

Family 344 (continued)

25023	*Decompression of forearm*	Code classified as big.
25028	*Drainage of forearm lesion*	Code classified as medium.
25031	*Drainage of forearm bursa*	Code classified as medium.
25035	*Treat forearm bone lesion*	Code classified as big.
25076	*Removal of forearm lesion*	Code classified as medium.
25077	*Remove tumor, forearm/wrist*	Code classified as medium.
25115	*Remove wrist/forearm lesion*	Code classified as big.
25116	*Remove wrist/forearm lesion*	Code classified as big.
25120	*Removal of forearm lesion*	Code classified as medium.
25125	*Remove/graft forearm lesion*	Code classified as big.
25126	*Remove/graft forearm lesion*	Code classified as medium.
25145	*Remove forearm bone lesion*	Code classified as big.
25151	*Partial removal of radius*	Code classified as big.
25170	*Extensive forearm surgery*	Code classified as medium.
25260	*Repair forearm tendon/muscle*	Code classified as big.
25263	*Repair forearm tendon/muscle*	Code classified as big.
25265	*Repair forearm tendon/muscle*	Code classified as big.
25270	*Repair forearm tendon/muscle*	Code classified as big.
25272	*Repair forearm tendon/muscle*	Code classified as big.
25274	*Repair forearm tendon/muscle*	Code classified as big.
25280	*Revise wrist/forearm tendon*	Code classified as big.
25295	*Release wrist/forearm tendon*	Code classified as big.
25310	*Transplant forearm tendon*	Code classified as big.
25312	*Transplant forearm tendon*	Code classified as big.
25315	*Revise palsy hand tendon(s)*	Code classified as big.
25316	*Revise palsy hand tendon(s)*	Code classified as big.

Family 344 (continued)

25350	*Revision of radius*	Code classified as medium.
25355	*Revision of radius*	Code classified as medium.
25360	*Revision of ulna*	Code classified as medium.
25365	*Revise radius & ulna*	Code classified as medium.
25370	*Revise radius or ulna*	Code classified as medium.
25375	*Revise radius & ulna*	Code classified as medium.
25390	*Shorten radius/ulna*	Code classified as medium.
25391	*Lengthen radius/ulna*	Code classified as medium.
25392	*Shorten radius & ulna*	Code classified as medium.
25393	*Lengthen radius & ulna*	Code classified as big.
25400	*Repair radius or ulna*	Code classified as medium.
25405	*Repair/graft radius or ulna*	Code classified as big.
25415	*Repair radius & ulna*	Code classified as medium.
25420	*Repair/graft radius & ulna*	Code classified as big.
25425	*Repair/graft radius or ulna*	Code classified as big.
25426	*Repair/graft radius & ulna*	Code classified as big.
25450	*Revision of wrist joint*	Code classified as medium.
25455	*Revision of wrist joint*	Code classified as medium.
25490	*Reinforce radius*	Code classified as medium.
25491	*Reinforce ulna*	Code classified as medium.
25492	*Reinforce radius and ulna*	Code classified as medium.
25526	*Repair fracture of radius*	Code classified as big.
25830	*Fusion radioulnar jnt/ulna*	Code classified as medium.
25900	*Amputation of forearm*	Code classified as medium.
25905	*Amputation of forearm*	Code classified as big.
25907	*Amputation follow-up surgery*	Code classified as medium.
25909	*Amputation follow-up surgery*	Code classified as medium.
25915	*Amputation of forearm*	Code classified as big.

Family 348 Orthopaedics - Elbow Joint and Surrounding Structures

Family-Level Notes

No family-level notes for family 348

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 348

Family 352 Orthopaedics - Upper Arm

Family-Level Notes

No family-level notes for family 352

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 352

Family 356 Orthopaedics - Shoulder Joint and Surrounding Structures

Family-Level Notes

No family-level notes for family 356

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 356

Family 360 Orthopaedics - Pelvis

Family-Level Notes

No family-level notes for family 360

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 360

Family 364 Orthopaedics - Spine

Family-Level Notes

1 Panel costed reference service as a ZZZ code with 0 clinical and 0 administrative time. Most codes in this family used the reference service from family 1516 (code 63030) as a basis for developing resource profiles.

Procedure-Specific Notes

Family 364 (continued)

20250	*Open bone biopsy*	Panel indicated that this code had no post-op visits even though it has a ten day global period.
20251	*Open bone biopsy*	Panel indicated that this code had no post-op visits even though it has a ten day global period.

Family 368 Orthopaedics - Miscellaneous

Family-Level Notes

No family-level notes for family 368

Procedure-Specific Notes

20615	*Treatment of bone cyst*	Panel indicated that this code had no post-op visits even though it has a ten day global period.

Family 372 Bone or Joint Manipulation under Anesthesia

Family-Level Notes

No family-level notes for family 372

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 372

Family 376 Arthrocentesis and Ligament or Tendon Injection

Family-Level Notes

No family-level notes for family 376

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 376

Family 380 Open or Percutaneous Treatment of Fractures

Family-Level Notes

1 Panel indicated that codes performed out-of-office in this family are done on an emergent basis, so there is never a G0 visit.

2 Panel divided part of this family into two groups: open treatment and percutaneous codes, in order to facilitate the costing process. These groups did not systematically affect the costing of the codes.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 380

Family 384 Closed Treatment of Fracture and Dislocation except Finger, Toe and Trunk

Family-Level Notes

1 Panel divided part of this family into two groups: functional and non-functional codes, in order to facilitate the costing process. These groups did not systematically affect the costing of the codes.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 384

Family 388 Closed Treatment of Fracture and Dislocation of Finger, Toe and Trunk

Family-Level Notes

No family-level notes for family 388

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 388

Family 392 Cast and Strapping

Family-Level Notes

No family-level notes for family 392

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 392

Family 700 Office Visits - New Patient

Family-Level Notes

No family-level notes for family 700

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 700

Family 704 Office Visits - Established Patient

Family-Level Notes

No family-level notes for family 704

Procedure-Specific Notes

Family 704 (continued)

99354	*Prolonged service, office*	Panel stated they treated this code like an add-on code (ZZZ), so they included no clinical time in the profile.
99355	*Prolonged service, office*	Panel stated they treated this code like an add-on code (ZZZ), so they included no clinical time in the profile.

Family 728 Consultation - Office

Family-Level Notes

No family-level notes for family 728

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 728

Family 1516 Major Procedure - Expior/Decompr/Excis Disc

Family-Level Notes

No family-level notes for family 1516

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1516

ID : E30021 Foot and Ankle Surgery Instrument

Total Price : $1,530 **Used by CPEP(s):** C 3

Components	*Price **
#64 beaver handle	N/A
Adson-Brown forcep	N/A
Adson-toothed forcep	N/A
Allis	N/A
Baby metz	N/A
Bone saw	N/A
Currette	N/A
Curved mosquito	N/A
Double-action bone cutter	N/A
Double-ended smooth elevator, Sayre	N/A
Dull single-ended elevator, Locke	N/A
File, double-ended	N/A
Freer elevator	N/A
Heavy-toothed forcep	N/A
Knife handle	N/A
Mallet	N/A
Medium oschner	N/A
Medium regular needle holder	N/A
Metz	N/A
Nail splitter, angled	N/A
Nail splitter, flat	N/A
Osteotomes	N/A
Rasp, double-ended	N/A
Regular towel clip	N/A
Senn retractor	N/A
Sharp elevator	N/A
Skin hook	N/A
Small bone cutter	N/A
Small curved mayo	N/A
Small curved rongeur	N/A
Small oschner	N/A
Small prep stick	N/A
Small regualr needle holder	N/A
Small self-retaining rake	N/A
Small straight roungeur	N/A
Small towel clip	N/A
Straight mosquito	N/A
Wire cleaning brush	N/A
Wire cutter	N/A

* *N/A = Not available.*

CPEP 4:
Obstetrics & Gynecology

Notes for CPEP C 4

CPEP-Level Notes

All in-office procedure-specific equipment usage is based on the longest time of a clinical staff type in the procedure (G1) period, except where noted otherwise.

1 The panel rarely provided time in the G1 out setting to indicate staff that accompany the physician to the hospital. In the majority of cases, G1 out time ranges from 5-13 minutes to reflect staff time in the physician's office attending to follow-up phone calls. Exceptions to this are noted at the code level.

2 For some 000 and 010 day global period services, the panel included a G0 visit.

Family 404 Pregnancy Related Tests

Family-Level Notes

1 The fertility specialist at the panel meeting provided data on many of the services in this family: 58323, 58800, 58970, 58972, 58974, and 58976.

Procedure-Specific Notes

58800	*Drainage of ovarian cyst(s)*	Even though this service has a 90 day global period, the panel did not provide post-op visit information. This service was profiled with this family rather than with family 452.
58970	*Retrieval of oocyte*	Panel indicated that 30 minutes of the RN time in the G1 out period only occurs when staff accompany the physician to the hospital. This scenario was considered typical. The remaining time in the G1 out, 10 minutes of a medical assistant and 30 minutes of an RN, occur in the physician's office for providing education and instructions to the patient.
58974	*Transfer of embryo*	Panel indicated that all G1 out time occurs when the lab tech accompanies the physician to the hospital. This scenario was considered typical.
58976	*Transfer of embryo*	Panel indicated that all G1 out time occurs when the lab tech accompanies the physician to the hospital. This scenario was considered typical.

Family 408 Pregnancy Hospital Procedures

Family-Level Notes

No family-level notes for family 408

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 408

Family 412 Delivery Services and Postpartum Care

Family-Level Notes

1 All antepartum and post partum visits are contained in the G1.X time period. The panel did not provide administrative times (G2.X) for any of the ante or post partum visits. Rather, the panel calculated the total administrative times for each service which encompassed the procedure and visits and provided this time in the G2 time period.

Procedure-Specific Notes

59400 Obstetrical care	The panel indicated that this service used equipment in the post-op visits. Therefore, an equipment exception time (sum of the maximum staff type time in the post-op visits) was calculated to estimate the use of the doppler in the post-op visits. This service does not have administrative time associated with visits (G2.X) because the panel calculated a total administrative time (G2) which included the administrative time for the visits. The panel stated that typically this service had 13 antepartum and 1 post partum visit.
59410 Obstetrical care	The panel indicated that this service used equipment in the post-op visits. Therefore, an equipment exception time (sum of the maximum staff type time in the post-op visits) was calculated to estimate the use of the doppler in the post-op visits. This service does not have administrative time associated with visits (G2.X) because the panel calculated a total administrative time (G2) which included the administrative time for the visits.
59425 Antepartum care only	The panel indicated that this service used equipment in the ante- and postpartum visits. Therefore, an equipment exception time (sum of the maximum staff type time in the G1.x visits) was calculated to estimate the use of the doppler in the G1.x visits. This service does not have administrative time associated with visits (G2.X) because the panel calculated a total administrative time (G2) which included the administrative time for the visits.
59426 Antepartum care only	The panel indicated that this service used equipment in the ante- and postpartum visits. Therefore, an equipment exception time (sum of the maximum staff type time in the G1.x visits) was calculated to estimate the use of the doppler in the G1.x visits. This service does not have administrative time associated with visits (G2.X) because the panel calculated a total administrative time (G2) which included the administrative time for the visits.
59430 Care after delivery	The panel indicated that this service used equipment in the post-op visits. Therefore, an equipment exception time (sum of the maximum staff type time in the post-op visits) was calculated to estimate the use of the doppler in the post-op visits. This service does not have administrative time associated with visits (G2.X) because the panel calculated a total administrative time (G2) which included the administrative time for the visits.

Family 412 (continued)

59510 Cesarean delivery	The panel indicated that this service used equipment in the post-op visits. Therefore, an equipment exception time (sum of the maximum staff type time in the post-op visits) was calculated to estimate the use of the doppler in the post-op visits. This service does not have administrative time associated with visits (G2.X) because the panel calculated a total administrative time (G2) which included the administrative time for the visits. The panel stated that this service typically had 13 antepartum and 2 post partum visits.
59515 Cesarean delivery	The panel indicated that this service used equipment in the post-op visits. Therefore, an equipment exception time (sum of the maximum staff type time in the post-op visits) was calculated to estimate the use of the doppler in the post-op visits. This service does not have administrative time associated with visits (G2.X) because the panel calculated a total administrative time (G2) which included the administrative time for the visits.

Family 416 Spontaneous and Therapeutic Abortion

Family-Level Notes

1 According to the abortion service representative, abortion clinics require security equipment (bullet proof glass, metal detector, alarm system) and a security guard. Additionally, approximately 69 % of all abortions were reported to be performed in clinics. Therefore, these equipment costs were allocated to the abortion services as overhead equipment.

Procedure-Specific Notes

59840 Abortion	The abortion services representative stated that this service typically has a longer service period (G1 in the office) to account for additional time required for counseling.
59841 Abortion	The abortion services representative stated that this service typically has a longer service period (G1 in the office) to account for additional time required for counseling and because the procedure itself takes more time.
59850 Abortion	This service does not have administrative time associated with visits (G2.X) because the panel said the administrative time for this service was identical to code 59410 for which they calculated a total administrative time (G2) that included administrative time for the visits.
59852 Abortion	This service does not have administrative time associated with visits (G2.X) because the panel said the administrative time for this service was identical to code 59515 for which they calculated a total administrative time (G2) that included administrative time for the visits.
59855 Abortion	This service does not have administrative time associated with visits (G2.X) because the panel said the administrative time for this service was identical to code 59410 for which they calculated a total administrative time (G2) that included administrative time for the visits.
59857 Abortion	This service does not have administrative time associated with visits (G2.X) because the panel said the administrative time for this service was identical to code 59515 for which they calculated a total administrative time (G2) that included administrative time for the visits.

Family 420 Dilation and Curettage

Family-Level Notes

No family-level notes for family 420

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 420

Family 424 Hysteroscopy

Family-Level Notes

No family-level notes for family 424

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 424

Family 428 Colposcopy

Family-Level Notes

No family-level notes for family 428

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 428

Family 432 Intrauterine Insertion and Removal

Family-Level Notes

No family-level notes for family 432

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 432

Family 436 Simple Laparoscopic Procedures

Family-Level Notes

No family-level notes for family 436

Procedure-Specific Notes

Family 436 (continued)

56360	*Peritoneoscopy*	The service has a zero day global period, and was profiled as such; but the panel questioned the appropriateness of the zero day global period.
56361	*Peritoneoscopy w/biopsy*	The service has a zero day global period, and was profiled as such; but the panel questioned the appropriateness of the zero day global period.

Family 440 Complex Laparoscopic Procedures

Family-Level Notes

No family-level notes for family 440

Procedure-Specific Notes

56308	*Laparoscopy; hysterectomy*	The panel indicated that the current global period for this service, 10 days, seemed too short. However, they profiled the service with 2 post-operative visits.

Family 444 Hysterectomy

Family-Level Notes

No family-level notes for family 444

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 444

Family 448 Hysterectomy - Oncology

Family-Level Notes

1 For this family of services the panel indicated that it was typical for staff to accompany the physician to a hospital setting. A clinical nurse specialist must explain to the patient about life with cancer, verify blood counts etc. Additionally, the panel stated that approximately 12 minutes in the G1 out setting was for the RN/MA to attend to follow-up phone calls in the physician's office.

2 The panel increased the times of the reference service which was profiled in the round 1 meetings after discussing it with the oncology representative. The oncology representative stated that over half of these patients require additional time in the post-operative period for counseling.

Procedure-Specific Notes

58200	*Extensive hysterectomy*	This service was profiled with this family rather than with family 444.
58210	*Extensive hysterectomy*	This service was profiled with this family rather than with family 444.
58285	*Extensive hysterectomy*	This service was profiled with this family rather than with family 444.
58943	*Removal of ovary(s)*	This service was profiled with this family rather than with family 464.

Family 452 Hysterectomy - Urology

Family-Level Notes

1 According to the panel, 15 minutes in the G1 out setting occurs when the nurse is at the hospital instructing the patient.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 452

Family 456 Simple Female Reproductive Procedures

Family-Level Notes

No family-level notes for family 456

Procedure-Specific Notes

59325	*Revision of cervix*	According to the panel, it was typical for staff to accompany the physician to the hospital to provide this service. The panel also indicated that 5 minutes of the G1 out time is for staff attending to follow-up phone calls in the physician's office.

Family 460 Complex Female Reproductive Procedures

Family-Level Notes

1 According to the panel, all G1 out time occurs when the nurse is at the hospital providing post procedure education.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 460

Family 464 Major Procedure - Female Reproductive

Family-Level Notes

No family-level notes for family 464

Procedure-Specific Notes

58611	*Ligate oviduct(s)*	The panel indicated that it was typical for staff to accompany the physician to provide this service.

Family 468 Miscellaneous Female Reproductive

Family-Level Notes

No family-level notes for family 468

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 468

Family 608 Obstetrical Ultrasound

Family-Level Notes

No family-level notes for family 608

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 608

Family 700 Office Visits - New Patient

Family-Level Notes

1 The panel stated that the main time driver in this family is the complexity of the cases, which determines the provision of the service and the level of patient education required. HCPCS code definitions are based on physician work. The panel thought that the times could not correlate to physician time and therefore did not refer to the Hsaio work time estimates in developing these profiles.

Procedure-Specific Notes

99205	*Office/outpatient visit, new*	The panel added 30 minutes of time to this service to account for more education, counseling, coordinating care, and scheduling of other procedures that are typically required.
99387	*Preventive visit,new, 65&over*	The panel stated that since this service is typically used with the elderly, it requires more time.

Family 704 Office Visits - Established Patient

Family-Level Notes

1 The panel stated that with managed care, codes 99401, 99402, 99403, and 99404 will probably be used more but currently they do not use them very often because they can't bill them since the patients are not sick. According to HCFA staff, these codes are typically used in the office to assess risk factors and could be considered special education or counseling sessions.

Procedure-Specific Notes

99354	*Prolonged service, office*	According to the panel, this service is typically used for asthmatic or diabetic pregnant patients

CPEP 5: Ophthalmology

Notes for CPEP C 5

CPEP-Level Notes

All in-office procedure-specific equipment usage is based on the longest time of a clinical staff type in the procedure (G1) period, except where noted otherwise.

1 Equipment types and usage were debated in detail by the panel. The panel determined that almost all codes used equipment contained in what are generically referred to as the "screening lane" and "exam lane." A profile of each of these lanes was developed, and the lanes were assigned to every code that used all or most of the equipment contained within them. A "central lane" or "pod," and multiple "trays" of equipment were also developed, and assigned to specific codes. Please see attached appendix for lists of equipment contained in each of these equipment groupings.

2 Since almost every code performed in the office used the exam and the screening lanes, the equipment contained within these lanes was considered overhead. The central lane and tray equipment were applied to specific codes, as indicated by the panel.

3 All out of office clinical time occurring in the G1/P1/M1 period is time associated with staff accompanying the physician to the hospital.

4 Because many ophthalmology codes require clinical staff to use equipment not only during the service itself (G1), but during the pre-service (G0) and post-service (G1.X) periods as well, there are many exceptions to the general rule for calculating equipment usage time. Any unique formula for calculating equipment usage time is documented at the code level.

5 Except where specifically noted otherwise, all in-office procedure-specific equipment use times are estimated by using the longest time of a clinical staff type in the procedure (G1) period.

6 For some 000 and 010 day global period services, the panel included a G0 visit.

Family 500 Simple Repair and Plastic Procedures of Eye

Family-Level Notes

1 The panel divided the codes into three groups: simple, intermediate and complex.

2 Code 67875 was assigned in the intermediate grouping; but this service has a zero day global period. One post-operative visit was entered to make this code consistent with all other intermediate level codes. This was approved by HCFA at the meeting. The time associated with this visit is:
Clinical in time: G1.1 31 minutes of an Ophthalmic Medical Professional
Administrative in time: G2.1 74 minutes of an Ophthalmic Business Professional
Clinical out time: G1.1 31 minutes of an Ophthalmic Medical Professional
Administrative out time: G2.1 74 minutes of an Ophthalmic Business Professional

3 For all intermediate and complex level codes, the physician takes loupes to the out of office setting.

Procedure-Specific Notes

Family 500 (continued)

65270	*Repair of eye wound*	Intermediate. Because this code requires the use of multiple pieces of equipment in multiple service periods, this is an exception to the general formula for calculating equipment usage time. In this case, the formula for calculating equipment usage time is based upon the following inputs: Minor instrument pack = G1 in + all G1.x in, Staff type is RN Minor instrument pack = all G1.x out, Staff type is RN Central pod and Designed for Vision loupes = G1 in, Staff type is RN There are three distinct times for the three distinct pieces of equipment used for this service. One in-office time and one out-of-office time were assigned to all three pieces of equipment. These assigned times were calculated to produce the same total cost for the HCPCS code as would have been produced using six distinct times (three times for the in-office, three times for the out-of-office). The assigned times are: Total equipment usage time in office= 83 Total equipment usage time out of office= 2
67700	*Drainage of eyelid abscess*	Simple
67710	*Incision of eyelid*	Simple
67715	*Incision of eyelid fold*	Simple
67800	*Remove eyelid lesion*	Simple
67801	*Remove eyelid lesions*	Intermediate. Because this code requires the use of multiple pieces of equipment in multiple service periods, this is an exception to the general formula for calculating equipment usage time. In this case, the formula for calculating equipment usage time is based upon the following inputs: Minor instrument pack = G1 in + all G1.x in, Staff type is RN Minor instrument pack = all G1.x out, Staff type is RN Central pod and Designed for Vision loupes = G1 in, Staff type is RN There are three distinct times for the three distinct pieces of equipment used for this service. One in-office time and one out-of-office time were assigned to all three pieces of equipment. These assigned times were calculated to produce the same total cost for the HCPCS code as would have been produced using six distinct times (three times for the in-office, three times for the out-of-office). The assigned times are: Total equipment usage time in office= 83 Total equipment usage time out of office= 2
67805	*Remove eyelid lesions*	Complex
67808	*Remove eyelid lesion(s)*	Complex
67810	*Biopsy of eyelid*	Simple
67820	*Revise eyelashes*	Simple
67825	*Revise eyelashes*	Simple

 DRAFT

Family 500 (continued)

67830 Revise eyelashes

Intermediate.
Because this code requires the use of multiple pieces of equipment in multiple service periods, this is an exception to the general formula for calculating equipment usage time. In this case, the formula for calculating equipment usage time is based upon the following inputs:
Minor instrument pack = G1 in + all G1.x in, Staff type is RN
Minor instrument pack = all G1.x out, Staff type is RN
Central pod and Designed for Vision loupes = G1 in, Staff type is RN

There are three distinct times for the three distinct pieces of equipment used for this service. One in-office time and one out-of-office time were assigned to all three pieces of equipment. These assigned times were calculated to produce the same total cost for the HCPCS code as would have been produced using six distinct times (three times for the in-office, three times for the out-of-office). The assigned times are:
Total equipment usage time in office= 83
Total equipment usage time out of office= 2

67840 Remove eyelid lesion

Intermediate.
Because this code requires the use of multiple pieces of equipment in multiple service periods, this is an exception to the general formula for calculating equipment usage time. In this case, the formula for calculating equipment usage time is based upon the following inputs:
Minor instrument pack = G1 in + all G1.x in, Staff type is RN
Minor instrument pack = all G1.x out, Staff type is RN
Central pod and Designed for Vision loupes = G1 in, Staff type is RN

There are three distinct times for the three distinct pieces of equipment used for this service. One in-office time and one out-of-office time were assigned to all three pieces of equipment. These assigned times were calculated to produce the same total cost for the HCPCS code as would have been produced using six distinct times (three times for the in-office, three times for the out-of-office). The assigned times are:
Total equipment usage time in office= 83
Total equipment usage time out of office= 2

67850 Treat eyelid lesion

Intermediate.
Because this code requires the use of multiple pieces of equipment in multiple service periods, this is an exception to the general formula for calculating equipment usage time. In this case, the formula for calculating equipment usage time is based upon the following inputs:
Minor instrument pack = G1 in + all G1.x in, Staff type is RN
Minor instrument pack = all G1.x out, Staff type is RN
Central pod and Designed for Vision loupes = G1 in, Staff type is RN

There are three distinct times for the three distinct pieces of equipment used for this service. One in-office time and one out-of-office time were assigned to all three pieces of equipment. These assigned times were calculated to produce the same total cost for the HCPCS code as would have been produced using six distinct times (three times for the in-office, three times for the out-of-office). The assigned times are:
Total equipment usage time in office= 83
Total equipment usage time out of office= 2

Family 500 (continued)

67875	*Closure of eyelid by suture*	Intermediate. Because this code requires the use of multiple pieces of equipment in multiple service periods, this is an exception to the general formula for calculating equipment usage time. In this case, the formula for calculating equipment usage time is based upon the following inputs: Minor instrument pack = G1 in + all G1.x in, Staff type is RN Minor instrument pack = all G1.x out, Staff type is RN Central pod and Designed for Vision loupes = G1 in, Staff type is RN There are three distinct times for the three distinct pieces of equipment used for this service. One in-office time and one out-of-office time were assigned to all three pieces of equipment. These assigned times were calculated to produce the same total cost for the HCPCS code as would have been produced using six distinct times (three times for the in-office, three times for the out-of-office). The assigned times are: Total equipment usage time in office= 83 Total equipment usage time out of office= 2
67880	*Revision of eyelid*	Intermediate. Because this code requires the use of multiple pieces of equipment in multiple service periods, this is an exception to the general formula for calculating equipment usage time. In this case, the formula for calculating equipment usage time is based upon the following inputs: Minor instrument pack = G1 in + all G1.x in, Staff type is RN Minor instrument pack = all G1.x out, Staff type is RN Central pod and Designed for Vision loupes = G1 in, Staff type is RN There are three distinct times for the three distinct pieces of equipment used for this service. One in-office time and one out-of-office time were assigned to all three pieces of equipment. These assigned times were calculated to produce the same total cost for the HCPCS code as would have been produced using six distinct times (three times for the in-office, three times for the out-of-office). The assigned times are: Total equipment usage time in office= 83 Total equipment usage time out of office= 2
67882	*Revision of eyelid*	Complex
67914	*Repair eyelid defect*	Intermediate. Because this code requires the use of multiple pieces of equipment in multiple service periods, this is an exception to the general formula for calculating equipment usage time. In this case, the formula for calculating equipment usage time is based upon the following inputs: Minor instrument pack = G1 in + all G1.x in, Staff type is RN Minor instrument pack = all G1.x out, Staff type is RN Central pod and Designed for Vision loupes = G1 in, Staff type is RN There are three distinct times for the three distinct pieces of equipment used for this service. One in-office time and one out-of-office time were assigned to all three pieces of equipment. These assigned times were calculated to produce the same total cost for the HCPCS code as would have been produced using six distinct times (three times for the in-office, three times for the out-of-office). The assigned times are: Total equipment usage time in office= 84 Total equipment usage time out of office= 2
67915	*Repair eyelid defect*	Simple
67916	*Repair eyelid defect*	Complex

Family 500 (continued)

67921	*Repair eyelid defect*	Intermediate. Because this code requires the use of multiple pieces of equipment in multiple service periods, this is an exception to the general formula for calculating equipment usage time. In this case, the formula for calculating equipment usage time is based upon the following inputs: Minor instrument pack = G1 in + all G1.x in, Staff type is RN Minor instrument pack = all G1.x out, Staff type is RN Central pod and Designed for Vision loupes = G1 in, Staff type is RN There are three distinct times for the three distinct pieces of equipment used for this service. One in-office time and one out-of-office time were assigned to all three pieces of equipment. These assigned times were calculated to produce the same total cost for the HCPCS code as would have been produced using six distinct times (three times for the in-office, three times for the out-of-office). The assigned times are: Total equipment usage time in office= 84 Total equipment usage time out of office= 2
67922	*Repair eyelid defect*	Simple
67923	*Repair eyelid defect*	Complex
67930	*Repair eyelid wound*	Intermediate. Because this code requires the use of multiple pieces of equipment in multiple service periods, this is an exception to the general formula for calculating equipment usage time. In this case, the formula for calculating equipment usage time is based upon the following inputs: Minor instrument pack = G1 in + all G1.x in, Staff type is RN Minor instrument pack = all G1.x out, Staff type is RN Central pod and Designed for Vision loupes = G1 in, Staff type is RN There are three distinct times for the three distinct pieces of equipment used for this service. One in-office time and one out-of-office time were assigned to all three pieces of equipment. These assigned times were calculated to produce the same total cost for the HCPCS code as would have been produced using six distinct times (three times for the in-office, three times for the out-of-office). The assigned times are: Total equipment usage time in office= 83 Total equipment usage time out of office= 2
67935	*Repair eyelid wound*	Complex
67938	*Remove eyelid foreign body*	Simple
68020	*Incise/drain eyelid lining*	Simple
68040	*Treatment of eyelid lesions*	Simple
68100	*Biopsy of eyelid lining*	Simple
68110	*Remove eyelid lining lesion*	Simple

Family 500 (continued)

68115	*Remove eyelid lining lesion*	Intermediate. Because this code requires the use of multiple pieces of equipment in multiple service periods, this is an exception to the general formula for calculating equipment usage time. In this case, the formula for calculating equipment usage time is based upon the following inputs: Minor instrument pack = G1 in + all G1.x in, Staff type is RN Minor instrument pack = all G1.x out, Staff type is RN Central pod and Designed for Vision loupes = G1 in, Staff type is RN There are three distinct times for the three distinct pieces of equipment used for this service. One in-office time and one out-of-office time were assigned to all three pieces of equipment. These assigned times were calculated to produce the same total cost for the HCPCS code as would have been produced using six distinct times (three times for the in-office, three times for the out-of-office). The assigned times are: Total equipment usage time in office= 83 Total equipment usage time out of office= 2
68135	*Remove eyelid lining lesion*	Simple
68340	*Separate eyelid adhesions*	Complex
68400	*Incise/drain tear gland*	Intermediate. Because this code requires the use of multiple pieces of equipment in multiple service periods, this is an exception to the general formula for calculating equipment usage time. In this case, the formula for calculating equipment usage time is based upon the following inputs: Minor instrument pack = G1 in + all G1.x in, Staff type is RN Minor instrument pack = all G1.x out, Staff type is RN Central pod and Designed for Vision loupes = G1 in, Staff type is RN There are three distinct times for the three distinct pieces of equipment used for this service. One in-office time and one out-of-office time were assigned to all three pieces of equipment. These assigned times were calculated to produce the same total cost for the HCPCS code as would have been produced using six distinct times (three times for the in-office, three times for the out-of-office). The assigned times are: Total equipment usage time in office= 83 Total equipment usage time out of office= 2
68420	*Incise/drain tear sac*	Intermediate. Because this code requires the use of multiple pieces of equipment in multiple service periods, this is an exception to the general formula for calculating equipment usage time. In this case, the formula for calculating equipment usage time is based upon the following inputs: Minor instrument pack = G1 in + all G1.x in, Staff type is RN Minor instrument pack = all G1.x out, Staff type is RN Central pod and Designed for Vision loupes = G1 in, Staff type is RN There are three distinct times for the three distinct pieces of equipment used for this service. One in-office time and one out-of-office time were assigned to all three pieces of equipment. These assigned times were calculated to produce the same total cost for the HCPCS code as would have been produced using six distinct times (three times for the in-office, three times for the out-of-office). The assigned times are: Total equipment usage time in office= 83 Total equipment usage time out of office= 2
68440	*Incise tear duct opening*	Simple
68510	*Biopsy of tear gland*	Complex
68525	*Biopsy of tear sac*	Complex

 DRAFT

Family 500 (continued)

68530	*Clearance of tear duct*	Complex
68705	*Revise tear duct opening*	Simple
68760	*Close tear duct opening*	Simple
68761	*Close tear duct opening*	Simple Although this code has a 10 day global period, the panel did not include in its profile any post-op visits.
68770	*Close tear system fistula*	Complex
68800	*Dilate tear duct opening(s)*	Simple
68820	*Explore tear duct system*	Intermediate. Because this code requires the use of multiple pieces of equipment in multiple service periods, this is an exception to the general formula for calculating equipment usage time. In this case, the formula for calculating equipment usage time is based upon the following inputs: Minor instrument pack = G1 in + all G1.x in, Staff type is RN Minor instrument pack = all G1.x out, Staff type is RN Central pod and Designed for Vision loupes = G1 in, Staff type is RN There are three distinct times for the three distinct pieces of equipment used for this service. One in-office time and one out-of-office time were assigned to all three pieces of equipment. These assigned times were calculated to produce the same total cost for the HCPCS code as would have been produced using six distinct times (three times for the in-office, three times for the out-of-office). The assigned times are: Total equipment usage time in office= 83 Total equipment usage time out of office= 2
68825	*Explore tear duct system*	Intermediate
68830	*Reopen tear duct channel*	Complex
68840	*Explore/irrigate tear ducts*	Simple
A4263	*Permanent tear duct plug*	Simple

Family 504 Complex Repair and Plastic Procedures of Eye

Family-Level Notes

1 The panel determined that codes within this family do not resemble each other, and therefore had difficulty relating them to the reference service. For profiling purposes, the codes were loosely grouped into ten categories: Blepharoplasty, Evisceration, Implant, Enucleation, Exenteration, Implant, Orbitotomy, Lid, Conjunctivoplasty, and Lacrimal.

2 The original reference service for the whole family became the reference service for just one of the ten categories, which was blepharoplasty.

Procedure-Specific Notes

15820	*Revision of lower eyelid*	Blepharoplasty
15821	*Revision of lower eyelid*	Blepharoplasty
15822	*Revision of upper eyelid*	Blepharoplasty

Family 504 (continued)

15823	*Revision of upper eyelid*	Blepharoplasty
65091	*Revise eye*	Evisceration
65093	*Revise eye with implant*	Evisceration
65101	*Removal of eye*	Enucleation
65103	*Remove eye/insert implant*	Enucleation
65105	*Remove eye/attach implant*	Enucleation
65110	*Removal of eye*	Exenteration
65112	*Remove eye, revise socket*	Exenteration
65114	*Remove eye, revise socket*	Exenteration
65125	*Revise ocular implant*	Implant
65130	*Insert ocular implant*	Implant
65135	*Insert ocular implant*	Implant
65140	*Attach ocular implant*	Implant
65150	*Revise ocular implant*	Implant
65155	*Reinsert ocular implant*	Implant
65175	*Removal of ocular implant*	Implant
67250	*Reinforce eye wall*	Implant
67255	*Reinforce/graft eye wall*	Implant
67400	*Explore/biopsy eye socket*	Orbitotomy The formula for the equipment usage time is: Central pod time = G0 out, staff type RN
67405	*Explore/drain eye socket*	Orbitotomy The formula for the equipment usage time is: Central pod time = G0 out, staff type RN
67412	*Explore/treat eye socket*	Orbitotomy The formula for the equipment usage time is: Central pod time = G0 out, staff type RN
67413	*Explore/treat eye socket*	Orbitotomy The formula for the equipment usage time is: Central pod time = G0 out, staff type RN
67414	*Explore/decompress eye socke*	Orbitotomy The formula for the equipment usage time is: Central pod time = G0 out, staff type RN
67445	*Explore/decompress eye socke*	Orbitotomy The formula for the equipment usage time is: Central pod time = G0 out, staff type RN
67550	*Insert eye socket implant*	Implant

 DRAFT

Fami. 504 (continued)

67560	*Revise eye socket implant*	Implant
67570	*Decompress optic nerve*	Orbitotomy
67835	*Revise eyelashes*	Lid
67900	*Repair brow defect*	Ptosis
67901	*Repair eyelid defect*	Ptosis
67902	*Repair eyelid defect*	Ptosis
67903	*Repair eyelid defect*	Ptosis
67904	*Repair eyelid defect*	Ptosis
67906	*Repair eyelid defect*	Ptosis
67908	*Repair eyelid defect*	Ptosis
67909	*Revise eyelid defect*	Ptosis
67911	*Revise eyelid defect*	Ptosis
67917	*Repair eyelid defect*	Blepharoplasty
67924	*Repair eyelid defect*	Blepharoplasty
67950	*Revision of eyelid*	Ptosis
67961	*Revision of eyelid*	Lid
67966	*Revision of eyelid*	Lid
67971	*Reconstruction of eyelid*	Lid
67973	*Reconstruction of eyelid*	Lid
67974	*Reconstruction of eyelid*	Lid
67975	*Reconstruction of eyelid*	Lid
68500	*Removal of tear gland*	Lacrimal
68505	*Partial removal tear gland*	Lacrimal
68520	*Removal of tear sac*	Lacrimal
68540	*Remove tear gland lesion*	Lacrimal
68550	*Remove tear gland lesion*	Lacrimal
68700	*Repair tear ducts*	Lacrimal
68720	*Create tear sac drain*	Lacrimal
68745	*Create tear duct drain*	Lacrimal

 DRAFT

Family 504 (continued)

68750	*Create tear duct drain*	Lacrimal

Family 508 Strabismus, Eye and Muscle Procedures

Family-Level Notes

No family-level notes for family 508

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 508

Family 512 Simple Posterior Segment Eye Procedures

Family-Level Notes

1 A formula was used to calculate the G1 in office time for all the non-reference services in this family.

Formula for G1 in office time:
Take the Hsiao time of profiled service
subtract the Hsiao time of reference service
add the Reference Service total time
the total is the G1 in office time for the profiled service

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 512

Family 516 Complex Posterior Segment Eye Procedures

Family-Level Notes

1 The same formula that was developed for F. 512 was used for Family 516's G1 out of office times for codes 67101, 67107, 67109, 67110, 67112. A different formula was used to determine the G1 in office time for these codes:

Formula for G1 in office time:
Take the G1 out of office time of the service (calculated using previous formula)
add 15 minutes
The total is the G1 in office time for that service

Procedure-Specific Notes

61330	*Decompress eye socket*	The formula for the equipment usage time is: Central pod time = G0 out, staff type RN
61332	*Explore/biopsy eye socket*	The formula for the equipment usage time is: Central pod time = G0 out, staff type RN
67420	*Explore/treat eye socket*	The formula for the equipment usage time is: Central pod time = G0 out, staff type RN
67430	*Explore/treat eye socket*	The formula for the equipment usage time is: Central pod time = G0 out, staff type RN

Family 516 (continued)

67440	*Explore/drain eye socket*	The formula for the equipment usage time is: Central pod time = G0 out, staff type RN
67450	*Explore/biopsy eye socket*	The formula for the equipment usage time is: Central pod time = G0 out, staff type RN

Family 520 Simple Anterior Segment Eye Procedures

Family-Level Notes

1 These codes were grouped into simple, intermediate and complex categories for profiling purposes, as noted below for each code.

2 All conjunctiva codes from F. 504 became part of the intermediate category of codes.

3 The panel thought that the codes with zero day global periods should have post-operative visits associated with them. HCFA representative affirmed that, per HCFA policy, no post-operative visits are allowed. However, although no post-operative visits were profiled or included in the database for any services in this family, the panel thought that code 65800 should have one post-operative visit.

Procedure-Specific Notes

65272	*Repair of eye wound*	Intermediate
65273	*Repair of eye wound*	Intermediate
65275	*Repair of eye wound*	Intermediate
65286	*Repair of eye wound*	Complex
65410	*Biopsy of cornea*	Intermediate
65420	*Removal of eye lesion*	Complex
65435	*Curette/treat cornea*	Intermediate
65436	*Curette/treat cornea*	Intermediate
65450	*Treatment of corneal lesion*	Complex
65600	*Revision of cornea*	Intermediate
65772	*Correction of astigmatism*	Intermediate
65800	*Drainage of eye*	Simple
65805	*Drainage of eye*	Simple
65810	*Drainage of eye*	Complex
65815	*Drainage of eye*	Complex
65820	*Relieve inner eye pressure*	Complex The formula for the equipment usage time is: Central pod time = G0 out + G1.x out, staff type RN
66020	*Injection treatment of eye*	Simple
66030	*Injection treatment of eye*	Simple

 DRAFT

Family 520 (continued)

66130	*Remove eye lesion*	Intermediate
66500	*Incision of iris*	Intermediate
66505	*Incision of iris*	Intermediate
66600	*Remove iris and lesion*	Complex
66625	*Removal of iris*	Complex
66630	*Removal of iris*	Complex
66682	*Repair iris and ciliary body*	Complex
66700	*Destruction, ciliary body*	Complex
66710	*Destruction, ciliary body*	Complex
66720	*Destruction, ciliary body*	Complex
66820	*Incision, secondary cataract*	Complex
66825	*Reposition intraocular lens*	Complex
68320	*Revise/graft eyelid lining*	Conjunctiva/Intermediate
68325	*Revise/graft eyelid lining*	Conjunctiva/Intermediate
68326	*Revise/graft eyelid lining*	Conjunctiva/Intermediate
68328	*Revise/graft eyelid lining*	Conjunctiva/Intermediate
68335	*Revise/graft eyelid lining*	Conjunctiva/Intermediate

Family 524 Moderate Anterior Segment Eye Procedures

Family-Level Notes

1 Codes in this family were grouped into simple, intermediate and complex categories for profiling. The driver for these categories was the number of follow up visits associated with each code. All simple codes have three post-operative visits, all intermediate codes have five post-operative visits and all complex codes have seven post-operative visits.

2 In a discussion about the equipment used for the family, the panel said that 50% of the time, physicians bring a cataract tray to the G1 out setting. Please see the attached appendix for the contents of the cataract tray.

Procedure-Specific Notes

65280	*Repair of eye wound*	Intermediate The formula for the equipment usage time is: Central pod time = G0 out + G1.n out (where n is the last post-op visit), staff type RN

Family 524 (continued)

65400	*Removal of eye lesion*	Intermediate Because this code requires the use of multiple pieces of equipment in multiple service periods, this is an exception to the general formula for calculating equipment usage time. In this case, the formula for calculating equipment usage time is based upon the following inputs: Cataract tray = G1 in, Staff type is RN Central pod = G0 in, G1.n in (where n is the last post-op visit), staff type is RN Central pod = G0 out, G1.n out (where n is the last post-op visit), staff type is RN There are three distinct times for the three distinct pieces of equipment used for this service. One in-office time and one out-of-office time were assigned to all three pieces of equipment. These assigned times were calculated to produce the same total cost for the HCPCS code as would have been produced using six distinct times (three times for the in-office, three times for the out-of-office). The assigned times are: Total equipment usage time in office= 65 Total equipment usage time out of office= 38
65426	*Removal of eye lesion*	Intermediate Because this code requires the use of multiple pieces of equipment in multiple service periods, this is an exception to the general formula for calculating equipment usage time. In this case, the formula for calculating equipment usage time is based upon the following inputs: Cataract tray = G1 in, Staff type is RN Central pod = G0 in, G1.n in (where n is the last post-op visit), staff type is RN Central pod = G0 out, G1.n out (where n is the last post-op visit), staff type is RN There are three distinct times for the three distinct pieces of equipment used for this service. One in-office time and one out-of-office time were assigned to all three pieces of equipment. These assigned times were calculated to produce the same total cost for the HCPCS code as would have been produced using six distinct times (three times for the in-office, three times for the out-of-office). The assigned times are: Total equipment usage time in office= 64 Total equipment usage time out of office= 38
65850	*Incision of eye*	Complex The formula for the equipment usage time is: Central pod time = G0 out + G1.n out (where n is the last post-op visit), staff type RN
65865	*Incise inner eye adhesions*	Intermediate The formula for the equipment usage time is: Central pod time = G0 out + G1.n out (where n is the last post-op visit), staff type RN
65870	*Incise inner eye adhesions*	Intermediate The formula for the equipment usage time is: Central pod time = G0 out + G1.n out (where n is the last post-op visit), staff type RN
65875	*Incise inner eye adhesions*	Intermediate The formula for the equipment usage time is: Central pod time = G0 out + G1.n out (where n is the last post-op visit), staff type RN
65880	*Incise inner eye adhesions*	Intermediate The formula for the equipment usage time is: Central pod time = G0 out + G1.n out (where n is the last post-op visit), staff type RN
65920	*Remove implant from eye*	Intermediate The formula for the equipment usage time is: Central pod time = G0 out + G1.n out (where n is the last post-op visit), staff type RN

 DRAFT

Family 524 (continued)

65930	*Remove blood clot from eye*	Complex The formula for the equipment usage time is: Central pod time = G0 out + G1.n out (where n is the last post-op visit), staff type RN
66150	*Glaucoma surgery*	Complex The formula for the equipment usage time is: Central pod time = G0 out + G1.n out (where n is the last post-op visit), staff type RN
66155	*Glaucoma surgery*	Complex The formula for the equipment usage time is: Central pod time = G0 out + G1.n out (where n is the last post-op visit), staff type RN
66160	*Glaucoma surgery*	Complex The formula for the equipment usage time is: Central pod time = G0 out + G1.n out (where n is the last post-op visit), staff type RN
66165	*Glaucoma surgery*	Complex The formula for the equipment usage time is: Central pod time = G0 out + G1.n out (where n is the last post-op visit), staff type RN
66170	*Glaucoma surgery*	Complex The formula for the equipment usage time is: Central pod time = G0 out + G1.n out (where n is the last post-op visit), staff type RN
66172	*Incision of eye*	Complex The formula for the equipment usage time is: Central pod time = G0 out + G1.n out (where n is the last post-op visit), staff type RN
66185	*Revise eye shunt*	Complex The formula for the equipment usage time is: Central pod time = G0 out + G1.n out (where n is the last post-op visit), staff type RN
66250	*Follow-up surgery of eye*	Intermediate Because this code requires the use of multiple pieces of equipment in multiple service periods, this is an exception to the general formula for calculating equipment usage time. In this case, the formula for calculating equipment usage time is based upon the following inputs: Cataract tray = G1 in, Staff type is RN Central pod = G0 in, G1.n in (where n is the last post-op visit), staff type is RN Central pod = G0 out, G1.n out (where n is the last post-op visit), staff type is RN There are three distinct times for the three distinct pieces of equipment used for this service. One in-office time and one out-of-office time were assigned to all three pieces of equipment. These assigned times were calculated to produce the same total cost for the HCPCS code as would have been produced using six distinct times (three times for the in-office, three times for the out-of-office). The assigned times are: Total equipment usage time in office= 65 Total equipment usage time out of office= 38
66635	*Removal of iris*	Intermediate The formula for the equipment usage time is: Central pod time = G0 out + G1.n out (where n is the last post-op visit), staff type RN

 DRAFT

Family 524 (continued)

66680	*Repair iris & ciliary body*	Intermediate The formula for the equipment usage time is: Central pod time = G0 out + G1.n out (where n is the last post-op visit), staff type RN
66740	*Destruction, ciliary body*	Intermediate The formula for the equipment usage time is: Central pod time = G0 out + G1.n out (where n is the last post-op visit), staff type RN
66830	*Removal of lens lesion*	Complex The formula for the equipment usage time is: Central pod time = G0 out + G1.n out (where n is the last post-op visit), staff type RN
68130	*Remove eyelid lining lesion*	Simple The formula for the equipment usage time is: Central pod time = G0 out + G1.n out (where n is the last post-op visit), staff type RN
68330	*Revise eyelid lining*	Simple Because this code requires the use of multiple pieces of equipment in multiple service periods, this is an exception to the general formula for calculating equipment usage time. In this case, the formula for calculating equipment usage time is based upon the following inputs: Cataract tray = G1 in, Staff type is RN Central pod = G0 in, G1.n in (where n is the last post-op visit), staff type is RN Central pod = G0 out, G1.n out (where n is the last post-op visit), staff type is RN There are three distinct times for the three distinct pieces of equipment used for this service. One in-office time and one out-of-office time were assigned to all three pieces of equipment. These assigned times were calculated to produce the same total cost for the HCPCS code as would have been produced using six distinct times (three times for the in-office, three times for the out-of-office). The assigned times are: Total equipment usage time in office= 63 Total equipment usage time out of office= 38
68360	*Revise eyelid lining*	Simple Because this code requires the use of multiple pieces of equipment in multiple service periods, this is an exception to the general formula for calculating equipment usage time. In this case, the formula for calculating equipment usage time is based upon the following inputs: Cataract tray = G1 in, Staff type is RN Central pod = G0 in, G1.n in (where n is the last post-op visit), staff type is RN Central pod = G0 out, G1.n out (where n is the last post-op visit), staff type is RN There are three distinct times for the three distinct pieces of equipment used for this service. One in-office time and one out-of-office time were assigned to all three pieces of equipment. These assigned times were calculated to produce the same total cost for the HCPCS code as would have been produced using six distinct times (three times for the in-office, three times for the out-of-office). The assigned times are: Total equipment usage time in office= 62 Total equipment usage time out of office= 38
68362	*Revise eyelid lining*	Complex The formula for the equipment usage time is: Central pod time = G0 out + G1.n out (where n is the last post-op visit), staff type RN

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Family 528 Complex Anterior Segment Eye Procedures

Family-Level Notes

No family-level notes for family 528

Procedure-Specific Notes

65775	*Correction of astigmatism*	The formula for the equipment usage time is: Corneal topography time = G0 out + all G1.x out , staff type COMT/COT/RN/CST
65900	*Remove eye lesion*	The formula for the equipment usage time is: Corneal topography time = all G1.x out , staff type COMT/COT/RN/CST
66605	*Removal of iris*	The formula for the equipment usage time is: Corneal topography time = all G1.x out , staff type COMT/COT/RN/CST

Family 532 Cataract Procedures

Family-Level Notes

No family-level notes for family 532

Procedure-Specific Notes

65235	*Remove foreign body from eye*	The panel decided to profile code 65235 under the assumption that it was without a cataract present (50% of the time, a cataract is not present).

Family 536 Laser Eye Procedures

Family-Level Notes

No family-level notes for family 536

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 536

Family 540 Vitrectomy

Family-Level Notes

No family-level notes for family 540

Procedure-Specific Notes

67005	*Partial removal of eye fluid*	The panel profiled code 67005 like a ZZZ code even though it has a 90 day global period code according to HCFA policy. Thus, according to the panel, there are no post-operative visits associated with this code.
67010	*Partial removal of eye fluid*	The panel profiled the reference service, code 67010, like a ZZZ code even though it has a 90 day global period code, according to HCFA policy. Thus, according to the panel, there are no post- operative visits associated with this code.

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Fan ily 544 Minor Ophthalmological Injection, Scraping and Tests

Family-Level Notes

1 This family was profiled according to the following formula:

P1 total in office time:
Reference service's P1 pre-service time
+ this service's Hsiao intra service time
+ Reference service's P1 post service time
= this service's P1 total in office time

P1 total out of office time:
This service's P1 total in office time
- this service's Hsiao intra service time
= this service's P1 total out of office time

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 544

Family 548 Minor Ophthalmological Tests and Procedures

Family-Level Notes

1 For profiling purposes, the codes were loosely grouped into five categories: Ultrasound, Fields, Photography, Tenography and Electrophysiology.

Procedure-Specific Notes

76511	*Echo exam of eye*	Ultrasound
76512	*Echo exam of eye*	Ultrasound
76513	*Echo exam of eye, water bath*	Ultrasound
76516	*Echo exam of eye*	Ultrasound
76519	*Echo exam of eye*	Ultrasound
76529	*Echo exam of eye*	Ultrasound
92081	*Visual field examination(s)*	Fields
92082	*Visual field examination(s)*	Fields
92083	*Visual field examination(s)*	Fields
92120	*Tonography & eye evaluation*	Tenography
92130	*Water provocation tonography*	Tenography
92140	*Glaucoma provocative tests*	Tenography
92230	*Eye exam with photos*	Photography
92235	*Eye exam with photos*	Photography
92250	*Eye exam with photos*	Photography

Family 548 (continued)

92265	*Eye muscle evaluation*	Electrophysiology
92270	*Electro-oculography*	Electrophysiology
92275	*Electroretinography*	Electrophysiology
92280	*Special eye evaluation*	Electrophysiology
92285	*Eye photography*	Photography
92286	*Internal eye photography*	Photography
92287	*Internal eye photography*	Photography

Family 552 Ophthalmology Evaluation and Management

Family-Level Notes

1 Codes 92015, 92020, 92225, 92226, 92260, 92283 have XXX global periods according to HCFA policy. However, the panel treated these codes as ZZZ codes for profiling purposes.

Procedure-Specific Notes

92012	*Eye exam established pt*	In attempts to price an "amblioscope," identified by the panel as an equipment item for this service, it was determined that this item is obsolete. The resource profile for this service does not include this item.
92015	*Refraction*	Treated as a ZZZ code.
92020	*Special eye evaluation*	Treated as a ZZZ code.
92060	*Special eye evaluation*	In attempts to price an "advanced vision training system," a "gross motor trainer," "hand-eye rotation trainers horizontal and vertical trainers," and an "ocular motor trainer - rotational," identified by the panel as equipment items for this service, it was determined that these items are obsolete. The resource profile for this service does not include these items.
92065	*Orthoptic/pleoptic training*	In attempts to price an "advanced vision training system," a "gross motor trainer," "hand-eye rotation trainers horizontal and vertical trainers," and an "ocular motor trainer - rotational," identified by the panel as equipment items for this service, it was determined that these items are obsolete. The resource profile for this service does not include these items.
92225	*Special eye exam, initial*	Treated as a ZZZ code.
92226	*Special eye exam, subsequent*	Treated as a ZZZ code.
92260	*Ophthalmoscopy/dynamometry*	Treated as a ZZZ code.
92283	*Color vision examination*	Treated as a ZZZ code.
92284	*Dark adaptation eye exam*	Code 92284, which also has a XXX global period according to HCFA policy, was treated by the panel as a ZZZ code for profiling purposes.

Family 556 Fitting of Contact Lenses and Spectacles

Family-Level Notes

1 Codes were grouped into simple, intermediate and complex groups for profiling. Simple codes are codes in which the staff person is supplying a product to the patient. Intermediate codes are codes in which the staff person must have technical expertise (like an optician or an ophthalmic technician) in order to make an adjustment. Complex codes are codes in which an MD is involved. The professional (usually an MD) must have prescriptive authority and provide medical supervision.

2 The panel said the reference service 92353 and 92358 are deleted codes, but they still profiled them.

Procedure-Specific Notes

92070	*Fitting of contact lens*	Complex. Treated like a ZZZ code for profiling purposes.
92310	*Contact lens fitting*	Complex
92311	*Contact lens fitting*	Complex
92312	*Contact lens fitting*	Complex
92313	*Contact lens fitting*	Complex
92314	*Prescription of contact lens*	Complex
92315	*Prescription of contact lens*	Complex
92316	*Prescription of contact lens*	Complex
92317	*Prescription of contact lens*	Complex
92325	*Modification of contact lens*	Intermediate
92326	*Replacement of contact lens*	Simple
92330	*Fitting of artificial eye*	Complex
92335	*Fitting of artificial eye*	Complex
92340	*Fitting of spectacles*	Intermediate
92341	*Fitting of spectacles*	Intermediate
92342	*Fitting of spectacles*	Intermediate
92352	*Special spectacles fitting*	Intermediate
92353	*Special spectacles fitting*	Intermediate. Deleted code.
92354	*Special spectacles fitting*	Complex
92355	*Special spectacles fitting*	Complex
92358	*Eye prosthesis service*	Simple. Deleted code.
92370	*Repair & adjust spectacles*	Simple
92371	*Repair & adjust spectacles*	Simple
92392	*Supply of low vision aids*	Simple
92393	*Supply of artificial eye*	Simple

Family 556 (continued)

92395	*Supply of spectacles*	Simple
92396	*Supply of contact lenses*	Simple

Family 700 Office Visits - New Patient

Family-Level Notes

No family-level notes for family 700

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 700

Family 704 Office Visits - Established Patient

Family-Level Notes

No family-level notes for family 704

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 704

Family 728 Consultation - Office

Family-Level Notes

No family-level notes for family 728

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 728

Summary of CPEP 5 "Lane" Composition

EQP_ID : E72005 Blepharoplasty Tray

Total Price: $1,950 Source : <Various>

Description	*Price*
Adson tissue forceps 1x2	$17
Backhaus towel forceps	$26
Barraquer needle holder, curved	$299
Bishop-Harmon dressing forceps	$148
Bishop-Harmon tissue forceps, 1x2	$109
Castroviejo caliper	$169
Castroviejo fixation forceps, 0.3 mm teeth	$209
Castroviejo needle holder, straight	$240
Castroviejo suturing forceps, 0.5 mm teeth	$20
Desmarres retractor	$47
Halstead mosquito hemostatic forceps, curved	$32
Halstead mosquito hemostatic forceps, straight	$31
Joseph double hook, 2 mm	$45
Joseph double hook, 5 mm	$45
Joseph single hook	$30
Stevens tenotomy scissors, curved	$87
Stevens tenotomy scissors, straight	$40
Storz double fixation hook	$49
Storz iris scissors, curved	$135
Stoz iris scissors, straight	$129
Webster needle holder	$44
stainless steel flexible ruler	$2

EQP_ID : E72007 Cataract Tray

Total Price: $11,261 Source : CPEP Member

Description	*Price*
Binkhorst cannulas	$52
Bishop-Harmon smooth forcep	$85
Calt needle holder	$347
Castroviejo forceps	$204
Colibri forceps	$249
Cyclodralynis Spatula	$75
Dewecker scissors	$312
IOL folder	$499
IOL holder	$486
Kelman McPherson forceps	$198
Koch spatula	$105
Kuglin hooks (2)	$350
Maloney spatula	$120
Schioty tonometer	$265
Utvata forceps	$349
Westcott scissors	$145

Wetfield cautery	$2,000
bond forceps	$357
calipers	$49
capsule polisher	$176
chopper spatula	$105
diamond knife	$3,100
instrument tray	$22
iris scissors long	$43
irrigator tips (BSS)	$15
knife handle (beaver)	$24
lens loop	$150
lens rotator	$148
lid speculum	$30
muscle hook	$46
needle holder(s)	$318
nucleus cracker	$353
olive tips	$24
sirrsky hook	$99
suture scissors - large	$35
suture scissors - small	$35
tenotomy scissors	$145
tying forceps	$148

EQP_ID : E71109 Exam Lane

Total Price: $31,046 Source : <Various>

Description	*Price*
20 D lens	$250
3 mirror lens	$325
90 D lens	$150
Amsler grid book	$68
Goldman applination tonometer	$1,420
Haag Streit (900 SL)	$6,561
Indirect ophthalmoscope	$1,440
Ishihara color test	$132
K-plate	$55
Keratometer	$2,090
Worth 4 dot test	$45
aesthesiometer	$370
cross cylinder	$32
direct ophthalmoscope	$171
distometer set	$84
exam chair	$4,495
keratometer arm	$295
near card	$8
occular occluder	$20
phoropter	$5,795
phoropter arm	$495
prism bar set	$113
prism set	$152

projector and slide sets	$866
refraction desk	$2,725
retinoscope	$256
scleral depressor	$21
screen and mirrors	$185
stand	$112
stereo fly test	$125
transilluminator	$68
trial frame	$198
trial lens set	$1,180
wall mount projector arm	$745

EQP_ID : E72004 Minor Equipment Pack

Total Price: $1,083 Source : <Various>

Description	*Price*
Foreign body kit	$77
forceps	$23
forceps (Castro)	$209
forceps (Cilia)	$79
rust ring remover	$556
scissors	$88
speculum (adult)	$24
speculum (infant)	$27

EQP_ID : E71112 Central (Pod) Equipment Lane

Total Price: $30,442 Source : <Various>

Description	*Price*
aesthesiometer	$370
auto lensometer	$2,095
autoclave	$1,750
autorefractor	$13,753
cautery	$6
chart	$20
electric table	$936
exophthalmometer	$30
fiberoptic headlight	$609
hand held Perkins tonometer	$910
light source	$1,070
manual lensometer	$1,750
optiokinetic drum	$179
pachymeter	$3,650
placido disc	$121
radiuscope	$399
tonopen	$2,795

EQP_ID : E71111 Screening Lane

Total Pr ce: $28,235 Source : <Various>

Description	*Price*
Amsler grid book	$68
Goldman applination tonometer	$1,420
Haag Streit (900 SL)	$6,561
Ishihara color test	$132
K-plate	$55
Worth 4 dot test	$45
cross cylinder	$32
exam chair	$4,495
keratometer	$2,090
keratometer arm	$295
near card	$8
occular occluder	$20
phoropter	$5,795
phoropter arm	$495
prism bar set	$113
prism set	$152
projector and slide sets	$866
refraction desk	$2,725
retinoscope	$256
screen and mirrors	$185
stand	$112
stereo-fly test	$125
transilluminator	$68
trial frame	$198
trial lens set	$1,180
wall mount projector arm	$745

EQP_ID : E72006 Minor Surgical Pack

Total Price: $1,597 Source : <Various>

Description	*Price*
2 single prong skin hooks	$100
Bowman probes #4	$37
Castroviejo needle holder	$239
Demarres retractor	$41
McCord needle	$65
Wesleott scissors	$145
blunt tip irrigating cannula	$17
colored corneal protector	$79
fine tipped hemostat mosquito	$52
instrument sterilizing container	$66
iris scissors	$30
knife handle #3	$9
punctal dilator	$62
small/medium chalazion clamp	$380
small/medium/large chalazion curette	$218

towel clips	$58

CPEP 6: Radiology

Notes for CPEP C 6

CPEP-Level Notes

All in-office procedure-specific equipment usage is based on the longest time of a clinical staff type in the procedure (G1) period, except where noted otherwise.

1 The equipment for most of the codes in this CPEP is unavailable for other uses while a patient is undergoing a radiological procedure in that room. Therefore, all equipment in that room is considered "in use." Based on this, procedure rooms were created in which the major pieces of equipment are included as a group. The lists of equipment that comprise each of these procedure rooms is attached in a separate file.

2 One panel member sent in an unsolicited room description for an Isotope Generation Room. The panel member did not provide any information regarding how this room applies to any of the radiological procedures. This panel member had provided solicited information for Nuclear Medicine families 636, 644, 648, 652, 656. The list of equipment that comprises this room is attached in a separate file.

Family 600 Plain Film

Family-Level Notes

1 The formula used to cost nearly all of the codes is as follows:

Clinical time = Ref. service 71020 (assuming 2 positions for x-ray) plus or minus three minutes to the number of positions required for the codes being profiled.

Administrative time = Ref. service 71020

Exceptions to this formula are noted at the code level.

Procedure-Specific Notes

71038	*X-ray guidance for biopsy*	The panel treated this code as a ZZZ code.
74210	*Contrast xray exam of throat*	Clinical and administrative times taken from reference service 74280.
74220	*Contrast xray exam, esophagus*	Clinical and administrative times taken from reference service 74280.
75989	*Abscess drainage under x-ray*	The administrative time was taken from reference service 75625.
76000	*Fluoroscope examination*	The administrative time was taken from reference service 74280.
76001	*Fluoroscope exam, extensive*	The administrative time was taken from reference service 74280.
76003	*Needle localization by x-ray*	The administrative time was taken from reference service 75625.
76096	*X-ray of needle wire, breast*	Code extrapolated reference service 76091.
76098	*X-ray exam, breast specimen*	Administrative time taken from reference service 76700.
76100	*X-ray exam of body section*	The administrative time was taken from reference service 71020. In attempts to price a "Hypercyoloidal Polytome," identified by the panel as an equipment item for this service, it was determined that this item is obsolete. The resource profile for this service does not include this item.
76101	*Complex body section x-ray*	The administrative time was taken from reference service 71020. In attempts to price a "Hypercyoloidal Polytome," identified by the panel as an equipment item for this service, it was determined that this item is obsolete. The resource profile for this service does not include this item.

Family 600 (continued)

76102	*Complex body section x-rays*	The administrative time was taken from reference service 71020. In attempts to price a "Hypercycloidal Polytome," identified by the panel as an equipment item for this service, it was determined that this item is obsolete. The resource profile for this service does not include this item.
76120	*Cinematic x-rays*	The administrative time was taken from reference service 71020.
76150	*X-ray exam, dry process*	The administrative time was taken from reference service 71020.
Q0092	*Set up port xray equipment*	Panel treated this code as a ZZZ code. This code is reported as being performed exclusively in the out setting according to BMAD data. The resources profiled by the panel are contained in the data set's out of office variables. It is important to note that the costs are always incurred by the practice due to the nature of portable X-ray services.
R0070	*Transport portable x-ray*	Panel treated this code as a ZZZ code. This code is reported as being performed exclusively in the out setting according to BMAD data. The resources profiled by the panel are contained in the data set's out of office variables. It is important to note that the costs are always incurred by the practice due to the nature of portable X-ray services.
R0075	*Transport port x-ray multipl*	No resources were assigned to this code. It was the understanding of the CPEP member who provided data that this code simply provides information as to the number of patients treated and does not affect the total amount reimbursed under code R0070.

Family 604 Mammography

Family-Level Notes

No family-level notes for family 604

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 604

Family 608 Obstetrical Ultrasound

Family-Level Notes

No family-level notes for family 608

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 608

Family 612 Diagnostic Ultrasound except Obstetrical

Family-Level Notes

No family-level notes for family 612

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 612

Family 616 Myelography and Diskography

Family-Level Notes

No family-level notes for family 616

Procedure-Specific Notes

62284	*Injection for myelogram*	The equipment exception time is tied to the X-Ray Tech time.
62290	*Inject for spine disk x-ray*	The equipment exception time is tied to the X-Ray Tech time.
62291	*Inject for spine disk x-ray*	The equipment exception time is tied to the X-Ray Tech time.

Family 620 Miscellaneous Radiological Procedures with Contrast

Family-Level Notes

No family-level notes for family 620

Procedure-Specific Notes

19030	*Injection for breast x-ray*	The equipment exception time is tied to the Angio Tech time.
20501	*Inject sinus tract for x-ray*	The equipment exception time is tied to the Angio Tech time.
36005	*Injection, venography*	The equipment exception time is tied to the Angio Tech time.
38790	*Injection for lymphatic xray*	The equipment exception time is tied to the Angio Tech time.
42550	*Injection for salivary x-ray*	The equipment exception time is tied to the Angio Tech time.
50394	*Injection for kidney x-ray*	The equipment exception time is tied to the Angio Tech time.
50690	*Injection for ureter x-ray*	The equipment exception time is tied to the Angio Tech time.
51600	*Injection for bladder x-ray*	The equipment exception time is tied to the Angio Tech time.
51605	*Preparation for bladder xray*	The equipment exception time is tied to the Angio Tech time.
51610	*Injection for bladder x-ray*	The equipment exception time is tied to the Angio Tech time.
58340	*Inject for uterus/tube x-ray*	The equipment exception time is tied to the Angio Tech time.

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Family 620 (continued)

58345	*Reopen fallopian tube*	Although this service has a 10 day global period, the panel stated that this code has no post operative visits.
68850	*Injection for tear sac x-ray*	The equipment exception time is tied to the Angio Tech time.

Family 624 Computerized Axial Tomography

Family-Level Notes

No family-level notes for family 624

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 624

Family 628 Magnetic Resonance Imaging

Family-Level Notes

No family-level notes for family 628

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 628

Family 632 Digestive Radiology

Family-Level Notes

No family-level notes for family 632

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 632

Family 636 Nuclear Cardiology

Family-Level Notes

No family-level notes for family 636

Procedure-Specific Notes

78478	*Heart wall motion (add-on)*	Although this is a XXX code, the panel reported zero administrative time.

Family 636 (continued)

78480	*Heart function, (add-on)*	Although this is a XXX code, the panel reported zero administrative time.

Family 640 Vascular Radiology except for Venography of Extremity

Family-Level Notes

No family-level notes for family 640

Procedure-Specific Notes

36218	*Place catheter in artery*	Panel treated this code as a ZZZ code.
36248	*Place catheter in artery*	Panel treated this code as a ZZZ code.
75774	*Artery x-ray, each vessel*	Panel treated this code as a ZZZ code.

Family 644 Simple Diagnostic Nuclear Medicine

Family-Level Notes

No family-level notes for family 644

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 644

Family 648 Intermediate Diagnostic Nuclear Medicine

Family-Level Notes

No family-level notes for family 648

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 648

Family 652 Complex Diagnostic Nuclear Medicine

Family-Level Notes

No family-level notes for family 652

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 652

Family 656 Therapeutic Nuclear Medicine

Family-Level Notes

1 The panel stated that for all nuclear medicine codes there are costs incurred by the practice for both a compliance officer, as well as a radiopharmacy. The panel was uncertain as to how to include these costs at a code or practice level, but asked that they be noted. These costs are not included in the database. The list of equipment that comprises this room is attached in a separate file.

Procedure-Specific Notes

78890	*Nuclear medicine data proc*	Panel reported zero administrative time.
78891	*Nuclear med data proc*	Panel reported zero administrative time.
79000	*Intial hyperthyroid therapy*	The equipment exception time is tied to the Nuclear Med. Tech time.
79001	*Repeat hyperthyroid therapy*	The equipment exception time is tied to the Nuclear Med. Tech time.
79020	*Thyroid ablation*	The equipment exception time is tied to the Nuclear Med. Tech time.
79030	*Thyroid ablation, carcinoma*	The equipment exception time is tied to the Nuclear Med. Tech time.
79035	*Thyroid metastatic therapy*	The equipment exception time is tied to the Nuclear Med. Tech time.
79100	*Hematopoetic nuclear therapy*	The equipment exception time is tied to the Nuclear Med. Tech time.
79400	*Nonhemato nuclear therapy*	The equipment exception time is tied to the Nuclear Med. Tech time.
79440	*Nuclear joint therapy*	The equipment exception time is tied to the Nuclear Med. Tech time.

Family 660 Radiation Therapy and Hyperthermia

Family-Level Notes

No family-level notes for family 660

Procedure-Specific Notes

77419	*Weekly radiation therapy*	This is a non-global service, however, the panel stated that there are visits that occur after the procedure has been completed that are not separately billable. HCFA staff instructed that the times be recorded for this additional time reported by the panel. The additional time was entered into the G1 and G2 periods as noted below. The additional G1 time for in and out sites of service was 5 minutes of an RN. The additional G2 time for in and out of sites service was 2 minutes of Insurance billing staff time; and 3 minutes of a medical secretary. The additional G2 time for the in site of service for a scheduling secretary was 2 minutes.
77420	*Weekly radiation therapy*	This is a non-global service, however, the panel stated that there are visits that occur after the procedure has been completed that are not separately billable. HCFA staff instructed that the times be recorded for this additional time reported by the panel. The additional time was entered into the G1 and G2 periods as noted below. The additional G1 time for in and out sites of service was 10 minutes of an RN. The additional G2 time for in and out of sites service was 4 minutes of Insurance billing staff time; and 6 minutes of a medical secretary. The additional G2 time for the in site of service for a scheduling secretary was 4 minutes.

Family 660 (continued)

77425	*Weekly radiation therapy*	This is a non-global service, however, the panel stated that there are visits that occur after the procedure has been completed that are not separately billable. HCFA staff instructed that the times be recorded for this additional time reported by the panel. The additional time was entered into the G1 and G2 periods as noted below. The additional G1 time for in and out sites of service was 8 minutes of an RN. The additional G2 time for in and out of sites service was 3 minutes of Insurance billing staff time; and 5 minutes of a medical secretary. The additional G2 time for the in site of service for a scheduling secretary was 3 minutes.
77430	*Weekly radiation therapy*	This is a non-global service, however, the panel stated that there are visits that occur after the procedure has been completed that are not separately billable. HCFA staff instructed that the times be recorded for this additional time reported by the panel. The additional time was entered into the G1 and G2 periods as noted below. The additional G1 time for in and out sites of service was 5 minutes of an RN. The additional G2 time for in and out of sites service was 2 minutes of Insurance billing staff time; and 3 minutes of a medical secretary. The additional G2 time for the in site of service for a scheduling secretary was 2 minutes.
77431	*Radiation therapy management*	This is a non-global service, however, the panel stated that there are visits that occur after the procedure has been completed that are not separately billable. HCFA staff instructed that the times be recorded for this additional time reported by the panel. The additional time was entered into the G1 and G2 periods as noted below. The additional G1 time for in and out sites of service was 30 minutes of an RN. The additional G2 time for in and out of sites service was 10 minutes of Insurance billing staff time; and 20 minutes of a medical secretary. The additional G2 time for the in site of service for a scheduling secretary was 10 minutes.
77432	*Stereotactic radiation trmt*	This is a non-global service, however, the panel stated that there are visits that occur after the procedure has been completed that are not separately billable. HCFA staff instructed that the times be recorded for this additional time reported by the panel. The additional time was entered into the G1 and G2 periods as noted below. The additional G1 time for in and out sites of service was 30 minutes of an RN. The additional G2 time for in and out of sites service was 10 minutes of Insurance billing staff time; and 20 minutes of a medical secretary. The additional G2 time for the in site of service for a scheduling secretary was 10 minutes.
77750	*Infuse radioactive materials*	The equipment exception time for this code is tied to the Nuclear Med Tech time.
77761	*Radioelement application*	The equipment exception time for this code is tied to the Radiation Tech. Therapist time.
77762	*Radioelement application*	The equipment exception time for this code is tied to the Radiation Tech. Therapist time.
77763	*Radioelement application*	The equipment exception time for this code is tied to the Radiation Tech. Therapist time.
77776	*Radioelement application*	This is a non-global service, however, the panel stated that there are visits that occur after the procedure has been completed that are not separately billable. HCFA staff instructed that the times be recorded for this additional time reported by the panel. The additional time was entered into the G1 and G2 periods as noted below. The additional G1 time for in and out sites of service was 30 minutes of an RN. The additional G2 time for in and out of sites service was 10 minutes of Insurance billing staff time; and 20 minutes of a medical secretary. The additional G2 time for the in site of service for a scheduling secretary was 10 minutes.
77777	*Radioelement application*	The equipment exception time for this code is tied to the Radiation Tech. Therapist time.

Family 660 (continued)

77778	*Radioelement application*	The GX time assigned code 77778 represents the time for two visits occurring after the initial procedure has been completed. The equipment exception time for this code is tied to the Radiation Tech. Therapist time.
77781	*High intensity brachytherapy*	The equipment exception time for this code is tied to the Radiation Tech. Therapist time.
77782	*High intensity brachytherapy*	The equipment exception time for this code is tied to the Radiation Tech. Therapist time.
77783	*High intensity brachytherapy*	The equipment exception time for this code is tied to the Radiation Tech. Therapist time.
77784	*High intensity brachytherapy*	The equipment exception time for this code is tied to the Radiation Tech. Therapist time.
77789	*Radioelement application*	The equipment exception time for this code is tied to the Radiation Tech. Therapist time.
77790	*Radioelement handling*	The equipment exception time for this code is tied to the Radiation Tech. Therapist time.

Family 664 Therapeutic Radiation Treatment Preparation

Family-Level Notes

No family-level notes for family 664

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 664

Family 699 Miscellaneous CPEP 6 Additions

Family-Level Notes

1 This family was created after the second round of CPEPs to consolidate various radiology codes. These codes had originally been assigned to other CPEPs, but the respective CPEPs were unfamiliar with the services and were therefore unable to profile the codes.

Procedure-Specific Notes

47510	*Insert catheter, bile duct*	The equipment exception time for this code defaults to the Angio Tech Time
47511	*Insert bile duct drain*	The equipment exception time for this code defaults to the Angio Tech Time

Family 800 Superficial Needle Biopsy and Aspiration

Family-Level Notes

No family-level notes for family 800

Procedure-Specific Notes

48102	*Needle biopsy, pancreas*	Although this service has a 10 day global period, the panel stated that this code has no post operative visits.

Family 1312 Angioplasty and Transcatheter Procedures, other than Coronary

Family-Level Notes

No family-level notes for family 1312

Procedure-Specific Notes

37209	*Exchange arterial catheter*	Panel treated this code as a ZZZ code.
37620	*Revision of major vein*	Although this service has a 90 day global period, the panel stated that this code has no post operative visits.

Summary of CPEP 6 "Room" Composition

ID : E51004 basic radiology room

Total Price : $150,000 Source : Seimens

Description	*Price **
50 kw generator w/x-ray tubes	N/A
elevating horizontal table w/floating top	N/A
overhead tube crane	N/A
tilting upright bucky	N/A

** N/A = Not available.*

ID : E51005 Radiographic/ fluoroscopic room

Total Price : $475,000 Source : CPEP Member

Description	*Price **
13 in 4 feild image	N/A
80 kw generator with x-ray tube	N/A
digital fluorescopy and image storage	N/A
overhead tube crane	N/A
r/f table 90/50 degree tilt	N/A
upright bucky	N/A

** N/A = Not available.*

ID : E51016 Mammography room

Total Price : $130,000 Source : Seimens

Description	*Price **
mamography stand and tube	N/A
stereo mammography adaptation	N/A

** N/A = Not available.*

ID : E51058 MR Room

Total Price : $3,140,000 Source : Seimens

Description	*Price **
1.5 Tesla MR	N/A
Echo planner programs	N/A
array body and spine coils	N/A
cardio package	N/A
digital film camera	N/A
extremity coils & flex coils	N/A
room prep and sheilding	N/A
ultra fast imaging	N/A

** N/A = Not available.*

ID : E51082 CT Room

Total Price : $1,000,000 Source : Seimens

Description	*Price **
high speed spiral scanner - subsecond scans	N/A
injector	N/A
laser imager	N/A
work station (2nd console)	N/A

** N/A = Not available.*

ID : E51084 angiographic room

Total Price : $1,580,000 Source : Seimens

Description	*Price **
14x14 cut film changer	N/A
16 in 4 field image system	N/A
80 kw generator with x-ray tube	N/A
full digital filming capabilities	N/A
laser film camera	N/A
pulsed floroscopy	N/A
single plane CARM	N/A
video recorder	N/A

** N/A = Not available.*

ID : E51086 chest room

Total Price : $200,000 Source : Seimens

Description	*Price **
50 kw x-ray generator and tube	N/A
automatic chest changer	N/A
ceiling tube crane or floor stand	N/A
film processor with direct feed	N/A

** N/A = Not available.*

ID : E52018 Ultrasound room

Total Price : $272,000 Source : CPEP Member

Description	*Price **
ATL HDI 3000 third probe	$12,000
ATL HDI 3000 w/ 2 transducers	$161,000
IMEX 9000 w/ 2 probe	$25,000
Megasonics CDS	$30,000
Parks Flo-Lab Model 2014	$26,000
Quinton Q4500 treadmill	$18,000

** N/A = Not available.*

ID : **Isotope Generator Room**

Total Price : **$2,327,500** **Source : CPEP Member**

Description	*Price* *
Rdiopharmaceutical production system	$300,000
chemistry unit	$300,000
computers	$25,000
cyclotron	$1,700,000
oscilloscope	$2,500

* *N/A = Not available.*

ID : **Radiopharmacy room**

Total Price : **$309,505** **Source : <Various>**

Description	*Price* *
4096 channel nucleus conductor	$2,000
6-200MR dosimeter & counter	$800
CRC 712R with Multichamber	$12,000
NOVA	$35,000
PH meter	$1,000
Packard gammar	$23,100
Rotavapor	$2,000
auto gammer	$2,000
balance A-200DS	$2,500
computers	$25,000
dose calibrator	$6,000
gas system	$26,000
hamilton heads and counters	$39,000
lab oven	$800
melting point	$700
other	$78,000
remote ion chamber (2)	$4,000
safe lead (2)	$6,750
sodium iodide detector	$5,600
transtector	$19,800
vacuum pumps	$1,455
water treatment system	$14,000
wavelength, Knauer	$2,000

* *N/A = Not available.*

CPEP 7:
Evaluation & Management

Notes for CPEP C 7

CPEP-Level Notes

All in-office procedure-specific equipment usage is based on the longest time of a clinical staff type in the procedure (G1) period, except where noted otherwise.

1 The original plan for conducting the second round of CPEPs was to have the CPEP review the total labor time estimates (clinical and administrative) that were established for each HCPCS code. CPEP 7 was used as the pilot test to evaluate this ranking verification process. On the second day of the CPEP, panel members were provided with reports that ranked the codes within each family according to the total clinical and administrative times. The CPEP reviewed these times and made the following changes during this process:

HCPCS codes 99354 and 99355: On the first day, the panel agreed that the administrative staff time for medical secretary/insurance/billing personnel should be 5 minutes for the in office setting. This was increased to 10 minutes during the ranking verification process.

HCPCS codes 99356 and 99357: On the first day, the panel agreed that the administrative staff time for medical secretary/insurance/billing personnel should be 2 minutes for the out-of-office setting. This was increased to 5 minutes during the ranking verification process.

HCPCS code 99295: On the first day, the panel agreed that the administrative staff time for medical secretary/insurance/billing personnel should be 60 minutes for the out-of-office setting. This was increased to 70 minutes during the ranking verification process.

Overall, the panel did not think that the ranking verification process was necessary; therefore, it was not implemented in subsequent CPEPs.

Family 392 Cast and Strapping

Family-Level Notes

1 G1 out-of-office clinical staff times reflect the time that office staff spend responding to phone calls from the patient during the post-procedure period.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 392

Family 700 Office Visits - New Patient

Family-Level Notes

No family-level notes for family 700

Procedure-Specific Notes

99385	*Preventive visit,new,18-39*	The panel indicated that 50% of the time a disposable speculum is used for HCPCS code 99385. Therefore, this supply was entered with the description, "disposable speculum 50% time". The quantity was entered as one unit, and the price was halved to reflect the use of this supply only 50% of the time.
99386	*Preventive visit,new,40-64*	The panel indicated that 50% of the time a disposable speculum is used for HCPCS code 99386. Therefore, this supply was entered with the description, "disposable speculum 50% time". The quantity was entered as one unit, and the price was halved to reflect the use of this supply only 50% of the time.

Family 700 (continued)

99387	*Preventive visit,new, 65&over*	The panel indicated that 50% of the time a disposable speculum is used for HCPCS code 99387. Therefore, this supply was entered with the description, "disposable speculum 50% time". The quantity was entered as one unit, and the price was halved to reflect the use of this supply only 50% of the time.

Family 704 Office Visits - Established Patient

Family-Level Notes

No family-level notes for family 704

Procedure-Specific Notes

99395	*Preventive visit,est,18-39*	The panel indicated that 50% of the time a disposable speculum is used for HCPCS code 99395. Therefore, this supply was entered with the description, "disposable speculum 50% time". The quantity was entered as one unit, and the price was halved to reflect the use of this supply only 50% of the time.
99396	*Preventive visit,est,40-64*	The panel indicated that 50% of the time a disposable speculum is used for HCPCS code 99396. Therefore, this supply was entered with the description, "disposable speculum 50% time". The quantity was entered as one unit, and the price was halved to reflect the use of this supply only 50% of the time.
99397	*Preventive visit,est,65&over*	The panel indicated that 50% of the time a disposable speculum is used for HCPCS code 99397. Therefore, this supply was entered with the description, "disposable speculum 50% time". The quantity was entered as one unit, and the price was halved to reflect the use of this supply only 50% of the time.

Family 708 Hospital Visit - Initial

Family-Level Notes

1 For codes 99218-99223, the panel stated that 50% of the time the patient is admitted from the office, and the other 50% of the time the patient is admitted from the emergency room (ER). Therefore, the G1 out-of-office clinical times are based on a weighted average of admission from the office and the ER. HCPCS Codes 99218, 99219, 99221 were considered equivalent to the reference service, which had a total time of 36 minutes (out-of-office) broken down as follows: 8 minutes pre-service time, 8 minutes intra-service time, and 20 minutes post-service time. The pre- and intra-service times were calculated as follows:

8 min pre = (12 min. office admission x 50%) + (4 min ER admission x 50%)
8 min intra = (15 min. office admission x 50%) + (0 min ER admission x 50%)

The post- service time of 20 minutes was not computed as a weighted average, as 20 minutes would be required when the patient is admitted from either setting. The resulting total time is 36 minutes (8 pre + 8 intra + 20 post). For HCPCS codes 99220 and 99223, 5 additional minutes were added to the total time of 36 minutes, yielding a total time of 41 minutes for these two codes.

When the patient is admitted from the office, the practice uses its own disposable supplies in providing HCPCS codes 99218-99223. Therefore, supplies for these codes were entered as follows: the notation "50% time" was added to the description for each code; the quantities were entered as whole units; and the prices were halved to reflect the use of each supply 50% of the time when the patient is admitted from the office.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 708

Family 712 Hospital Visit - Subsequent

Family-Level Notes

No family-level notes for family 712

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 712

Family 716 Hospital Visit - Critical Care

Family-Level Notes

No family-level notes for family 716

Procedure-Specific Notes

99291	*Critical care, first hour*	The G1 out-of-office staff time for HCPCS code 99291 in Family 712 denotes the time required to prepare/review the patient's chart in the pre-service period (2 minutes), as well as the time required to review the results and respond to phone calls from the patient in the post-service period (10 minutes).

Family 720 Emergency Room Visit

Family-Level Notes

1 For codes 99281-99285, the panel stated that 50% of the time the physician is already at the hospital, and the patient is admitted directly from the emergency room. However, the other 50% of the time the patient is admitted from the physician's office. Therefore, the GI out-of-office clinical times reflect the time that office staff spend on the patient when he/she is admitted from the office. Each of HCPCS Codes 99281-99285 were considered equivalent to the reference service, which had a total time of 7 minutes (out-of-office) broken down as follows: 3 minutes pre-service time, 4 minutes post-service time. The pre- and post-service times were calculated as follows:

3 min pre = (6 min. office admission x 50%) + (0 min ER admission x 50%)
4 min post = (8 min. office admission x 50%) + (0 min ER admission x 50%)

Thus, the resulting total time is 7 minutes.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 720

Family 724 Consultation - Inpatient

Family-Level Notes

1 According to the panel, the G1 out-of-office clinical staff times for HCPCS codes 99251-99275 reflect time that office staff spend on pre- and post-service functions. HCPCS codes 99251-99255 and 99271-99275 were considered equivalent to the out-of-office staff times for the reference service (HCPCS 99253). The out-of-office times for the reference service were allocated as follows: 5 minutes for pre-service functions and 7 minutes for post-service functions, resulting in the total time of 12 minutes. For HCPCS codes 99261-99263, 6 minutes were deducted from the total time of 12 minutes. The panel indicated that in comparison with the follow-up consultations (99261-99263), the initial consultations (99251-99275) require more time for preparing/reviewing patient charts, and the final consultations (99271-99275) require more time for providing final education/instructions to the patient and responding to calls.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 724

Family 728 Consultation - Office

Family-Level Notes

1 The G1 out-of-office clinical staff times for HCPCS codes 99241 - 99245 reflect the time that practice staff spend preparing/reviewing the patient's chart in the pre-service period, as well as the time required to review the results and respond to phone calls from the patient in the post-service period. The G1 out-of-office times do not include intra time.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 728

Family 732 Home Visit, New Patient

Family-Level Notes

1 The G1 clinical out-of-office staff times and supplies listed for these codes reflect the practice resources required to provide home health visits. During the panel, HCFA confirmed that staff time and supplies associated with home health visits are valid practice expenses.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 732

Family 736 Home Visit, Established Patient

Family-Level Notes

1 The G1 clinical out-of-office staff times and supplies listed for these codes reflect the practice resources required to provide home health visits. During the panel, HCFA confirmed that staff time and supplies associated with home health visits are valid practice expenses.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 736

Family 740 Nursing Facility Care, Initial

Family-Level Notes

1 The G1 out-of-office staff times in this family reflect the time that staff spend on pre- and post-service functions, as well as intra-service functions. The panel said that staff accompany the physician to the nursing home 25% of the time. A weighted time estimate of 5 minutes (25% x 20 minutes RN/LPN) was provided for the intra-service period for the reference service (99302). The pre-service time for the reference service was 10 minutes for preparing/reviewing the patient's charts; the post-service time was 22 minutes for reviewing results/responding to calls. (The pre- and post-service times were not based on a weighted average, as the panel stated that practice staff would perform these pre- and post-service functions regardless of whether or not they accompany the physician to the nursing home.) Thus, the resulting total time for HCPCS 99302 is 37 minutes (10 minutes pre + 5 minutes intra + 22 minutes post). The panel subtracted five minutes from this total time to derive the time estimate for 99301 and added 5 minutes to the total time to derive the time estimate for 99303.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 740

Family 744 Nursing Facility Care, Subsequent

Family-Level Notes

1 As in Family 740, the G1 out-of-office clinical staff times in this family reflect the time that staff spend on pre- and post-service functions, as well as intra-service functions. The panel said that staff accompany the physician to the nursing home 25% of the time. A weighted time estimate of 2 minutes (25% x 8 minutes RN/LPN) was provided for the intra-service period for the reference service (99312). The pre-service time for the reference service was 1 minute for preparing/reviewing the patient's charts; the post-service time was 8 minutes for reviewing results/responding to calls. (These times were not based on a weighted average because practice staff will perform these functions regardless of where the service is provided.) Thus, the resulting total time for HCPCS 99312 is 11 minutes (1 minute pre + 2 minutes intra + 8 minutes post). The panel subtracted 3 minutes from this total time to derive the time estimate for 99311 and added 3 minutes to the total time to derive the time estimate for 99313.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 744

Family 748 Specialist - Psychiatry

Family-Level Notes

1 The G1 out-of-office clinical staff times are based on the panel's explanation that practice/office staff accompany the psychiatrist on visits to nursing facilities or assisted care settings, which are a significant share of the services psychiatrists provide out-of-the office. Therefore, these times are associated with visits to those settings.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 748

Fami y 752 Neuropsychological Testing

Family-Level Notes

1 With HCFA's approval, the decision was made during the panel to include the psychologist's time as an allowed practice expense for the psychological and neuropsychological testing codes (90830, 95880, 95881, 95882, 95883, 99178). This decision was made because these codes have 0 work RVUs, which precludes the psychologist from billing separately for services he/she renders in association with these codes.

As defined in the AMA's 1995 Current Procedural Terminology (CPT), each of the psychological/neuropsychological testing codes is equivalent to one hour of face-to-face time spent with the patient. However, the panel explained that for each CPT "testing" code, the psychologist typically conducts a series of tests with the patient that requires greater than 60 minutes (1 hour) to complete (e.g., the tests involved in performing a developmental evaluation (CPT 95881) demand more than 1 hour of the psychologist's time). According to the panel, a typical "testing" session with a patient would require 4 hours of face-to-face time. HCFA staff confirmed that the resource requirements for these codes must remain consistent with the CPT definition. Therefore, the intra (face-to-face) time was established as 60 minutes for each code; 4 minutes of pre-service and 30 minutes of post-service time were also included in the clinical staff time estimates. As explained by HCFA staff, the psychologist is permitted to submit multiple claims (using the same CPT code) for each hour of face-to-face time provided to the same patient on the same day and would, therefore, be appropriately compensated for any additional hours spent with the patient.

As noted above, the panel agreed that the typical patient requires a total of 4 hours of face-to-face time. Panel members stated that the clinical staff time requirements are consistent across each hour spent directly with the patient (4 minutes pre, 60 minutes intra, 30 minutes post). However, the administrative staff time requirements, and the equipment and supply inputs are not consistent across each hour of service. The administrative staff time estimates for the typical patient are listed in the table below. The average time was calculated from these estimates to determine the administrative time required for the typical patient.

Table A. Administrative Time Requirements for Psychological Testing Codes

Hour	Insurance/Billing Staff Time	Medical Secretary Time
1st hour	20 minutes	35 minutes
2nd hour	5 minutes	35 minutes
3rd hour	5 minutes	35 minutes
4th hour	5 minutes	35 minutes
Average time	9 minutes	35 minutes

2 The panel also explained that for each type of testing code, different tests with distinct costs are used in evaluating the patient. The panel was therefore asked to identify which tests were typically used in providing these services. These tests and their associated costs are listed in Table B. For each test that is performed, a form is completed to detail the results of the test. According to the panel, the test forms are the only disposable supplies used in the provision of these services. These forms are also listed in Table B. The average price of the equipment (i.e., test) and supplies (i.e., test forms) was calculated to determine the resource costs associated with these services. As illustrated in Table B, the average price of the tests used in providing 90830 and 95880 was less than $500; therefore, these inputs were not included in the data file EQPDET. The supply items for 95881, 99178, 95882, and 95883, which averaged more than $500 were included in the data file.

Table B. Equipment and Supply Requirements

HCPCS Code	Equipment (Tests) Used Description	Price	Disposable Supplies Used Description	Price
90830	WAIS-R	$595	WAIS-R Test Form	$2.80
	MMPI I	$80	MMPI Test Form	$2.66
	MMPI II	$295	MMPII Test Form	$2.66
	WISC-R-III	$595	WISC-R Test Form	$2.48
	Rorschach	$145	Rorschach Test Form	$0.90
Average price		$342		$2.30
95880	FAS Word Fluency	$0	FAS Test Form	$0.50
	Boston Naming Test	$32	Boston Test Form	$1.36
	Aphasia Screen Test	$50	Aphasia Test Form	$0.50
Average price		$27		$0.95
95881	WISC-R-III	$595	WISC-R Test Form	$2.48
and	Stanford Binet	$595	Stanford Test Form	$2.80
99178				
Average price		$595		$2.64
95882	MMPI I	$80	MMPI I Test Form	$2.66
and	MMPI II	$295	MMPI II Test Form	$2.66
95883	WAIS-R	$595	WAIS-R Test Form	$2.80
	WMS-R	$294	WMS-R Test Form	$1.22
	Trailmaking Test A&B	$40	Trailmaking Form	$0.40
	Halstead-Reitan	$3,000	Halstead-Reitan Form	$25.00
Average price		$717		$5.77

The psychologist performs a significant number of the psychological/neuropsychological testing codes in out-of-office settings. Therefore, since the psychologist is considered part of the practice expense component of these codes, the time that he/she spends performing these tests out of the office was included in the G1 clinical out-of-office times. According to the panel, when providing these services out of the office, the psychologist brings the equipment (i.e., tests) and supplies (i.e., test forms), as listed in Table B, to the out-of-office settings.

3 Six of the 8 biofeedback codes (90900-90915) in this family were listed as being performed in the in-office setting only based on 1994 Medicare volume data. However, CPEP members agreed that all of these biofeedback codes are performed both in and out of the office. The panel maintained that when providing these services out of the office, an RN from the practice/office accompanies the psychologist to the out-of-office settings, including the hospital. Therefore, the G1 out-of-office clinical staff times reflect the time required by the RN to assist in rendering these services. According to the panel, the psychologist brings the equipment (i.e., laptop computer with biofeedback software) and disposable supplies (i.e., electrode conductive jelly) to the out-of-office settings. The out-of-office equipment requirements are reflected in data file OUTEQCAP. Alcohol and cotton swabs were included in the list of disposable supplies used in providing these services in the office; however, the panel indicated that only the electrode jelly would be brought to the out-of-office setting (i.e., the hospital or other facility would furnish the alcohol and cotton swabs).

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Family 752 (continued)

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 752

Family 756 Electroconvulsive Therapy

Family-Level Notes

1 The G1 out-of-office clinical staff times for the two codes in this family (90870 and 90871) denote the time that practice/office staff spend preparing/reviewing the patient's chart in the pre-service period, as well as the time required to review the results and respond to phone calls from the patient in the post-service period. The G1 times do not include time associated with intra-service functions.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 756

Family 1013 Simple Immunology Tests

Family-Level Notes

No family-level notes for family 1013

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1013

Family 1052 Respiratory Therapy

Family-Level Notes

No family-level notes for family 1052

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1052

Family 1332 Cardiogram

Family-Level Notes

No family-level notes for family 1332

Procedure-Specific Notes

Family 1332 (continued)

93000	*Electrocardiogram, complete*	The panel indicated that 50% of the time a disposable razor is used for HCPCS code 93000 in Family 1332. Therefore, this supply was entered with the description, "disposable razor 50% time". The quantity was entered as one unit, and the price was halved to reflect the use of this supply only 50% of the time.
93005	*Electrocardiogram, tracing*	The panel indicated that 50% of the time a disposable razor is used for HCPCS code 93005 in Family 1332. Therefore, this supply was entered with the description, "disposable razor 50% time". The quantity was entered as one unit, and the price was halved to reflect the use of this supply only 50% of the time.
93012	*Transmission of ecg*	The panel indicated that 50% of the time a disposable razor is used for HCPCS code 93012 in Family 1332. Therefore, this supply was entered with the description, "disposable razor 50% time". The quantity was entered as one unit, and the price was halved to reflect the use of this supply only 50% of the time.
93040	*Rhythm ECG with report*	The panel indicated that 50% of the time a disposable razor is used for HCPCS code 93040 in Family 1332. Therefore, this supply was entered with the description, "disposable razor 50% time". The quantity was entered as one unit, and the price was halved to reflect the use of this supply only 50% of the time.
93041	*Rhythm ECG, tracing*	The panel indicated that 50% of the time a disposable razor is used for HCPCS code 93041 in Family 1332. Therefore, this supply was entered with the description, "disposable razor 50% time". The quantity was entered as one unit, and the price was halved to reflect the use of this supply only 50% of the time.

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CPEP 8: General Surgery

Notes for CPEP C 8

CPEP-Level Notes

All in-office procedure-specific equipment usage is based on the longest time of a clinical staff type in the procedure (G1) period, except where noted otherwise.

1 The panel applied a consistent method of profiling to all families in the CPEP. The primary drivers of time were post-op visits and length of stay visits which were captured individually for each service where appropriate.

2 G0 - visit : During the round 1 meeting in February when the reference services were profiled, the panel debated at length whether a G0 visit was appropriate. The panel decided that 15 minutes in the G0 period was necessary for an RN to review pre-admission testing results. Thus, during round 2 the panel used the G0 visit time of 15 minutes for all services that require time for an RN to review pre-admission testing results.

3 G1 - OUT: The panel indicated that all time occurring in the G1 out period, only occurs when staff accompany the physician to the hospital.

G1 out intra service time was largely generated from either the Hsaio or RUC 5 year review times that were provided to the panel to aid in profiling. When the panel did not agree with these times, consensus estimates were provided by the panel. All intra service time reflects the time a scrub nurse / RN accompanies the physician to the hospital.

G1 out post service time was derived from a formula to account for length of stay visits during which an RN would accompany the physician to the hospital to assist with rounds. The panel stated 15 minutes of RN time was used to provide post procedure education/counseling, and attend to follow-up phone calls. In addition to this 15 minute base, the panel added 15 minutes for each length of stay visit when the RN would go to the hospital on rounds. Several codes in the CPEP had length of stay visits of 20 minutes to reflect ICU visits.
The panel indicated when there were no length of stay visits in order to adjust the G1 out post time appropriately (this time usually ranged from 15 to 30 minutes).

4 The panel profiled all ZZZ global period codes performed in the office with clinical time. All ZZZ codes performed out of the office had clinical time associated with staff that accompanied the physician. The panel stated that ZZZ codes did not have any administrative or equipment costs.

5 "Equipment trays" were developed and assigned to specific codes. Please see attached appendix for lists of equipment contained in each of these equipment groupings.

6 For some 000 and 010 day global period services, the panel included a G0 visit.

Family 220 Testicular and Epididymal Procedures

Family-Level Notes

No family-level notes for family 220

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 220

Family 436 Simple Laparoscopic Procedures

Family-Level Notes

No family-level notes for family 436

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 436

Family 700 Office Visits - New Patient

Family-Level Notes

1 According the panel, the complexity of the intra service time was the key driver for costing all services in this family.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 700

Family 704 Office Visits - Established Patient

Family-Level Notes

No family-level notes for family 704

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 704

Family 712 Hospital Visit - Subsequent

Family-Level Notes

1 One CPEP member questioned whether it was typical for a nurse to go on hospital rounds. The surgeons indicated that it was typical for their nurse to accompany them.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 712

Family 724 Consultation - Inpatient

Family-Level Notes

1 One CPEP member did not think it was typical for doctors to bring nurses to the hospital to assist with consultations.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 724

Family 728 Consultation - Office

Family-Level Notes

No family-level notes for family 728

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 728

Family 800 Superficial Needle Biopsy and Aspiration

Family-Level Notes

No family-level notes for family 800

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 800

Family 804 Simple Incision and Excision of Breast

Family-Level Notes

No family-level notes for family 804

Procedure-Specific Notes

19125 Excision, breast lesion	This service is listed as a zero day global, but the global period changed to 90 days in the 1995 Federal Register. The panel profiled it with 2 post-op visits. Thus, the inputs associated with the G1.X, G2.X , and supplies in the out setting reflect these visits.

Family 808 Breast Procedures

Family-Level Notes

1 Services in this family were grouped into benign and malignant cases which primarily served to establish the length of the first post-op visit. Benign services had a first post-op visit of 68 minutes while malignant services had a first post-op visit of 108 minutes. The type of service (benign or malignant) is indicated at the code level.

Procedure-Specific Notes

19110 Nipple exploration	This service was profiled as typically benign. An equipment exception time was generated to estimate the amount of time the surgical tray was used during the in office procedure portion of the service. Since the panel provided time estimates of this service to reflect the use of 2 RN's, the equipment exception time reflects the staff time of 1 RN. The formula used to calculate the exception time in the G1 in office site is: 30 minutes pre G1 (1 RN) +Hsiao intra G1 (1 nurse) + 15 minutes post G1 to clean the room (1 RN) + 15 minutes post G1 to wash instruments (1 RN).

Family 808 (continued)

19112	*Excise breast duct fistula*	This service was profiled as typically benign. An equipment exception time was generated to estimate the amount of time the surgical tray was used during the in office procedure portion of the service. Since the panel provided time estimates of this service to reflect the use of 2 RN's, the equipment exception time reflects the staff time of 1 RN. The formula used to calculate the exception time in the G1 in office site is: 30 minutes pre G1 (1 RN) +Hsiao intra G1 (1 nurse) + 15 minutes post G1 to clean the room (1 RN) + 15 minutes post G1 to wash instruments (1 RN).
19140	*Removal of breast tissue*	This service was profiled as typically benign. An equipment exception time was generated to estimate the amount of time the surgical tray was used during the in office procedure portion of the service. Since the panel provided time estimates of this service to reflect the use of 2 RN's, the equipment exception time reflects the staff time of 1 RN. The formula used to calculate the exception time in the G1 in office site is: 30 minutes pre G1 (1 RN) +Hsiao intra G1 (1 nurse) + 15 minutes post G1 to clean the room (1 RN) + 15 minutes post G1 to wash instruments (1 RN).
19160	*Removal of breast tissue*	This service was profiled as typically malignant.
19162	*Remove breast tissue, nodes*	This service was profiled as typically malignant.
19180	*Removal of breast*	This service was profiled as typically malignant.
19182	*Removal of breast*	This service was profiled as typically benign.
19200	*Removal of breast*	This service was profiled as typically malignant.
19220	*Removal of breast*	This service was profiled as typically malignant.
19240	*Removal of breast*	This service was profiled as typically malignant.
19355	*Correct inverted nipple(s)*	This service was profiled as typically benign. An equipment exception time was generated to estimate the amount of time the surgical tray was used during the in office procedure portion of the service. Since the panel provided time estimates of this service to reflect the use of 2 RN's, the equipment exception time reflects the staff time of 1 RN. The formula used to calculate the exception time in the G1 in office site is: 30 minutes pre G1 (1 RN) +Hsiao intra G1 (1 nurse) + 15 minutes post G1 to clean the room (1 RN) + 15 minutes post G1 to wash instruments (1 RN).

Family 812 Esophagus

Family-Level Notes

1 Services in this family were grouped into benign and malignant cases which primarily served to establish the length of the first post-op visit. Benign services had a first post -op visit of 58 minutes while malignant services had a first post-op visit of 153 minutes. The type of service (benign or malignant) is indicated at the code level.

Procedure-Specific Notes

43107	*Removal of esophagus*	This service was profiled as typically malignant.
43108	*Removal of esophagus*	This service was profiled as typically malignant.
43112	*Removal of esophagus*	This service was profiled as typically malignant.

 DRAFT

Family 812 (continued)

43113	*Removal of esophagus*	This service was profiled as typically malignant.
43116	*Partial removal of esophagus*	This service was profiled as typically malignant.
43117	*Partial removal of esophagus*	This service was profiled as typically malignant.
43118	*Partial removal of esophagus*	This service was profiled as typically malignant.
43121	*Partial removal of esophagus*	This service was profiled as typically malignant.
43122	*Partial removal of esophagus*	This service was profiled as typically malignant.
43123	*Partial removal of esophagus*	This service was profiled as typically malignant.
43124	*Removal of esophagus*	This service was profiled as typically malignant.
43130	*Removal of esophagus pouch*	This service was profiled as typically benign.
43135	*Removal of esophagus pouch*	This service was profiled as typically benign.
43320	*Fuse esophagus & stomach*	This service was profiled as typically benign.
43324	*Revise esophagus & stomach*	This service was profiled as typically benign.
43325	*Revise esophagus & stomach*	This service was profiled as typically benign.
43326	*Revise esophagus & stomach*	This service was profiled as typically benign.
43330	*Repair of esophagus*	This service was profiled as typically benign.
43331	*Repair of esophagus*	This service was profiled as typically benign.
43340	*Fuse esophagus & intestine*	This service was profiled as typically malignant.
43341	*Fuse esophagus & intestine*	This service was profiled as typically malignant.
43350	*Surgical opening, esophagus*	This service was profiled as typically benign.
43351	*Surgical opening, esophagus*	This service was profiled as typically benign.
43352	*Surgical opening, esophagus*	This service was profiled as typically benign.
43360	*Gastrointestinal repair*	This service was profiled as typically malignant.
43361	*Gastrointestinal repair*	This service was profiled as typically malignant.
43400	*Ligate esophagus veins*	This service was profiled as typically benign.
43401	*Esophagus surgery for veins*	This service was profiled as typically benign.
43405	*Ligate/staple esophagus*	This service was profiled as typically benign.

Family 812 (continued)

43410	*Repair esophagus wound*	This service was profiled as typically benign.
43415	*Repair esophagus wound*	This service was profiled as typically benign.
43420	*Repair esophagus opening*	This service was profiled as typically benign.
43425	*Repair esophagus opening*	This service was profiled as typically benign.
43460	*Pressure treatment esophagus*	This service was profiled as typically benign.

Family 816 Diaphragm

Family-Level Notes

1 All services in this family were profiled as benign which primarily served to establish the length of the first post-op visit (58 minutes).

Procedure-Specific Notes

39501	*Repair diaphragm laceration*	This service was profiled as typically benign.
39502	*Repair paraesophageal hernia*	This service was profiled as typically benign.
39503	*Repair of diaphragm hernia*	This service was profiled as typically benign.
39520	*Repair of diaphragm hernia*	This service was profiled as typically benign.
39530	*Repair of diaphragm hernia*	This service was profiled as typically benign.
39531	*Repair of diaphragm hernia*	This service was profiled as typically benign.
39540	*Repair of diaphragm hernia*	This service was profiled as typically benign.
39541	*Repair of diaphragm hernia*	This service was profiled as typically benign.

Family 820 Gastric Procedures

Family-Level Notes

1 Services in this family were grouped into benign and malignant cases (with the exception of the bariatric services - codes 43842-43848) which primarily served to establish the length of the first post-op visit. Benign services had a first post-op visit of 58 minutes while malignant services had an additional 10 minutes (total of 68 minutes) for the first post-op visit .

Procedure-Specific Notes

43500	*Surgical opening of stomach*	This service was profiled as typically benign.
43501	*Surgical repair of stomach*	This service was profiled as typically benign.
43502	*Surgical repair of stomach*	This service was profiled as typically benign.
43510	*Surgical opening of stomach*	This service was profiled as typically malignant.

Family 820 (continued)

43520	*Incision of pyloric muscle*	This service was profiled as typically benign.
43605	*Biopsy of stomach*	This service was profiled as typically benign.
43610	*Excision of stomach lesion*	This service was profiled as typically benign.
43611	*Excision of stomach lesion*	This service was profiled as typically malignant.
43620	*Removal of stomach*	This service was profiled as typically malignant.
43621	*Removal of stomach*	This service was profiled as typically malignant.
43622	*Removal of stomach*	This service was profiled as typically malignant.
43631	*Removal of stomach, partial*	This service was profiled as typically benign.
43632	*Removal stomach, partial*	This service was profiled as typically benign.
43633	*Removal stomach, partial*	This service was profiled as typically benign.
43634	*Removal stomach, partial*	This service was profiled as typically benign.
43635	*Partial removal of stomach*	This service was profiled as typically benign.
43638	*Partial removal of stomach*	This service was profiled as typically benign.
43639	*Removal stomach, partial*	This service was profiled as typically benign.
43640	*Vagotomy & pylorus repair*	This service was profiled as typically benign.
43641	*Vagotomy & pylorus repair*	This service was profiled as typically benign.
43750	*Place gastrostomy tube*	This service was profiled as typically benign.
43800	*Reconstruction of pylorus*	This service was profiled as typically benign.
43810	*Fusion of stomach and bowel*	This service was profiled as typically benign.
43820	*Fusion of stomach and bowel*	This service was profiled as typically benign.
43825	*Fusion of stomach and bowel*	This service was profiled as typically benign.
43830	*Place gastrostomy tube*	This service was profiled as typically benign.
43831	*Place gastrostomy tube*	This service was profiled as typically benign.
43832	*Place gastrostomy tube*	This service was profiled as typically benign.
43840	*Repair of stomach lesion*	This service was profiled as typically benign.
43842	*Gastroplasty for obesity*	An equipment exception time was generated for this service to reflect the use of equipment in the out site of service for the post-op visits. The total exception time is the total time of the post-op visits in the out setting.
43843	*Gastroplasty for obesity*	An equipment exception time was generated for this service to reflect the use of equipment in the out site of service for the post-op visits. The total exception time is the total time of the post-op visits in the out setting.

 DRAFT

Family 820 (continued)

43846	*Gastric bypass for obesity*	An equipment exception time was generated for this service to reflect the use of equipment in the out site of service for the post-op visits. The total exception time is the total time of the post-op visits in the out setting.
43847	*Gastric bypass for obesity*	An equipment exception time was generated for this service to reflect the use of equipment in the out site of service for the post-op visits. The total exception time is the total time of the post-op visits in the out setting.
43848	*Revision gastroplasty*	An equipment exception time was generated for this service to reflect the use of equipment in the out site of service for the post-op visits. The total exception time is the total time of the post-op visits in the out setting.
43850	*Revise stomach-bowel fusion*	This service was profiled as typically benign.
43855	*Revise stomach-bowel fusion*	This service was profiled as typically benign.
43860	*Revise stomach-bowel fusion*	This service was profiled as typically benign.
43865	*Revise stomach-bowel fusion*	This service was profiled as typically benign.
43870	*Repair stomach opening*	This service was profiled as typically benign.
43880	*Repair stomach-bowel fistula*	This service was profiled as typically benign.

Family 824 Small Intestinal Procedures

Family-Level Notes

No family-level notes for family 824

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 824

Family 828 Hernia Procedures

Family-Level Notes

1 The services in this family were grouped into 4 categories:

A. Pediatric

B. Strangulated

C. Adults and Initials (Incarcerated cases were considered typical for the panel said they occur 3-4 times more frequent than estrangulated)

D. Recurrent

The post-op visits for pediatric services typically took longer amounts of time than the other 3 groups.

Procedure-Specific Notes

49250	*Excision of umbilicus*	This service was classified in the pediatric subgroup.

Family 828 (continued)

49495	*Repair inguinal hernia, init*	This service was classified in the pediatric subgroup.
49496	*Repair inguinal hernia, init*	This service was classified in the pediatric subgroup. The panel said this code was typically estrangulated. For pediatric cases, estrangulated hernias would be approximately 40 minutes longer than incarcerated.
49500	*Repair inguinal hernia*	This service was classified in the pediatric subgroup.
49501	*Repair inguinal hernia, init*	This service was classified in the pediatric subgroup.
49505	*Repair inguinal hernia*	This service was classified in the estrangulated subgroup.
49507	*Repair, inguinal hernia*	This service was classified in the adult / initial subgroup where incarcerated cases were considered typical.
49520	*Rerepair inguinal hernia*	This service was classified in the recurrent hernia subgroup.
49521	*Repair inguinal hernia, rec*	This service was classified in the adult / initial subgroup where incarcerated cases were considered typical.
49525	*Repair inguinal hernia*	This service was classified in the strangulated subgroup.
49540	*Repair lumbar hernia*	This service was classified in the strangulated subgroup.
49550	*Repair femoral hernia*	This service was classified in the strangulated subgroup.
49553	*Repair femoral hernia, init*	This service was classified in the adult / initial subgroup where incarcerated cases were considered typical.
49555	*Repair femoral hernia*	This service was classified in the recurrent hernia subgroup.
49557	*Repair femoral hernia, recur*	This service was classified in the adult / initial subgroup where incarcerated cases were considered typical.
49560	*Repair abdominal hernia*	This service was classified in the strangulated subgroup.
49561	*Repair incisional hernia*	This service was classified in the adult / initial subgroup where incarcerated cases were considered typical.
49565	*Rerepair abdominal hernia*	This service was classified in the recurrent hernia subgroup.
49566	*Repair incisional hernia*	This service was classified in the adult / initial subgroup where incarcerated cases were considered typical.
49570	*Repair epigastric hernia*	This service was classified in the strangulated subgroup.
49572	*Repair, epigastric hernia*	This service was classified in the adult / initial subgroup where incarcerated cases were considered typical.
49585	*Repair umbilical hernia*	This service was classified in the strangulated subgroup.
49587	*Repair umbilical hernia*	This service was classified in the adult / initial subgroup where incarcerated cases were considered typical.
49590	*Repair abdominal hernia*	This service was classified in the strangulated subgroup.
49600	*Repair umbilical lesion*	This service was classified in the pediatric subgroup.
49606	*Repair umbilical lesion*	This service was classified in the pediatric subgroup.
49610	*Repair umbilical lesion*	This service was classified in the pediatric subgroup.

Family 832 Appendectomy and Miscellaneous Abdominal Procedures

Family-Level Notes

No family-level notes for family 832

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 832

Family 836 Cholecystectomy

Family-Level Notes

No family-level notes for family 836

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 836

Family 840 Hepatic and Bile Duct Procedures Except Cholecystectomy

Family-Level Notes

1 Services in this family were grouped into benign, malignant, and benign complex cases which primarily served to establish the length of the first post-op visit. Benign services had a first post-op visit of 58 minutes while malignant and benign complex services had a first post-op visit of 153 minutes. The type of service is indicated at the code level.

Procedure-Specific Notes

47010	*Drainage of liver lesion*	This service was profiled as typically benign.
47015	*Inject/aspirate liver cyst*	This service was profiled as typically benign.
47100	*Wedge biopsy of liver*	This service was profiled as typically benign.
47300	*Surgery for liver lesion*	This service was profiled as typically benign.
47350	*Repair liver wound*	This service was profiled as typically benign.
47355	*Repair liver wound*	This service was profiled as typically benign.
47360	*Repair liver wound*	This service was profiled as typically benign.
47400	*Incision of liver duct*	This service was profiled as typically benign.
47420	*Incision of bile duct*	This service was profiled as typically benign.
47425	*Incision of bile duct*	This service was profiled as typically benign.
47460	*Incise bile duct sphincter*	This service was profiled as typically benign.
47480	*Incision of gallbladder*	This service was profiled as typically benign.

Family 840 (continued)

47490	*Incision of gallbladder*	This service was profiled as typically benign.
47550	*Bile duct endoscopy*	Although this service has a zero day global period, the panel profiled it as a ZZZ code with no administrative , supply, or equipment costs.
47700	*Exploration of bile ducts*	This service was profiled as typically benign but complex.
47701	*Bile duct revision*	This service was profiled as typically benign but complex.
47711	*Excision of bile duct tumor*	This service was profiled as typically benign but complex. The panel also assumed that this service was with primary repair.
47712	*Excision of bile duct tumor*	This service was profiled as typically benign but complex.
47715	*Excision of bile duct cyst*	This service was profiled as typically benign.
47716	*Fusion of bile duct cyst*	This service was profiled as typically benign.
47720	*Fuse gallbladder & bowel*	This service was profiled as typically malignant.
47721	*Fuse upper gi structures*	This service was profiled as typically malignant.
47740	*Fuse gallbladder & bowel*	This service was profiled as typically malignant.
47741	*Fuse gallbladder & bowel*	This service was profiled as typically malignant.
47760	*Fuse bile ducts and bowel*	This service was profiled as typically malignant with 1 anastomosis.
47765	*Fuse liver ducts & bowel*	This service was profiled as typically malignant with 2 anastomoses.
47780	*Fuse bile ducts and bowel*	This service was profiled as typically malignant.
47785	*Fuse bile ducts and bowel*	This service was profiled as typically malignant.
47800	*Reconstruction of bile ducts*	This service was profiled as typically malignant.
47801	*Placement, bile duct support*	This service was profiled as typically malignant.
47802	*Fuse liver duct & intestine*	This service was profiled as typically malignant.
47900	*Suture bile duct injury*	This service was profiled as typically benign but complex.

Family 844 Hepatectomy and Pancreatectomy

Family-Level Notes

1 All services in this family were considered malignant, thus consistent with the profiling of malignant cases in other families, the first post-op visit had a total time of 153 minutes.

2 The services in this family had length of stay days in the hospital, captured in the G1 post service portion, that ranged from 7 to 18 days. The time for the length of stays varied according to whether they were ICU days (20 minutes of RN time per day) or general acute care hospital days (15 minutes of RN time per hospital day).

Procedure-Specific Notes

Family 844 (continued)

47134	*Partial removal,donor liver*	This panel profiled this service as if a living donor was typical by providing post-op visit and length of stay information. However, since this service is a XXX code, the post-op visit and length of stay information was not incorporated in the final time profiles for the service, but are provided below: Clinical time: G1 out - 155 minutes RN (reflects 10 length of stay visits: 1 @ 20 minutes + 9 @ 15) 4 POVs G1.X - out 212 minutes RN/MA 20 minutes Medical secretary 105 minutes RN Admin time: G2.X - 80 minutes transcriptionist 39 minutes medical secretary Supplies - The panel stated that the supply profile for the post-op visits of this service would be identical to the supply profile of code 47130. Equipment - none

Family 848 Pancreatic Procedures

Family-Level Notes

1 Services in this family were grouped into benign and malignant cases which primarily served to establish the length of the first post-op visit. Benign services had a first post-op visit of 58 minutes while malignant services had a first post-op visit of 153 minutes. The type of service (benign or malignant) is indicated at the code level.

Procedure-Specific Notes

48000	*Drainage of abdomen*	This service was profiled as typically benign.
48001	*Placement of drain, pancreas*	This service was profiled as typically benign.
48005	*Resect/debride pancreas*	This service was profiled as typically benign.
48020	*Removal of pancreatic stone*	This service was profiled as typically benign.
48100	*Biopsy of pancreas*	This service was profiled as typically malignant.
48120	*Removal of pancreas lesion*	This service was profiled as typically benign.
48140	*Partial removal of pancreas*	This service was profiled as typically malignant.
48145	*Partial removal of pancreas*	This service was profiled as typically malignant.
48148	*Removal of pancreatic duct*	This service was profiled as typically malignant.
48180	*Fuse pancreas and bowel*	This service was profiled as typically benign.

Family 848 (continued)

48500	*Surgery of pancreas cyst*	This service was profiled as typically benign.
48510	*Drain pancreatic pseudocyst*	This service was profiled as typically benign.
48520	*Fuse pancreas cyst and bowel*	This service was profiled as typically benign.
48540	*Fuse pancreas cyst and bowel*	This service was profiled as typically benign.
48545	*Pancreatorrhaphy*	This service was profiled as typically benign.
48547	*Duodenal exclusion*	This service was profiled as typically benign.
48556	*Removal, allograft pancreas*	This service was profiled as typically malignant.

Family 852 Colectomy

Family-Level Notes

No family-level notes for family 852

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 852

Family 856 Colectomy, Complex

Family-Level Notes

No family-level notes for family 856

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 856

Family 860 General Complex Laparoscopic

Family-Level Notes

No family-level notes for family 860

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 860

Family 864 Simple Anal and Rectal Procedures

Family-Level Notes

1 Any service in this family that used an anal tray required an equipment exception time to reflect the use of the tray in the post-op visits. The in office equipment exception time reflects the sum of the procedure and post-op visit time of the longest clinical staff type while the out office equipment exception time reflects the longest clinical staff type time in the post-op visits only.

Procedure-Specific Notes

45900	*Reduction of rectal prolapse*	Even though this service has a 10 day global period, the panel stated that it did not typically have any post-op visits.
45905	*Dilation of anal sphincter*	Even though this service has a 10 day global period, the panel stated that it did not typically have any post-op visits.
45910	*Dilation of rectal narrowing*	Even though this service has a 10 day global period, the panel stated that it did not typically have any post-op visits.
45915	*Remove rectal obstruction*	Even though this service has a 10 day global period, the panel stated that it did not typically have any post-op visits.

Family 868 Complex Anal and Rectal Procedures

Family-Level Notes

1 Any service in this family that used an anal tray required an equipment exception time to reflect the use of the tray in the post-op visits. The in office equipment exception time reflects the sum of the procedure and post-op visit time of the longest clinical staff type while the out office equipment exception time reflects the longest clinical staff type time in the post-op visits only.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 868

Family 872 Proctectomy and Rectal Repairs

Family-Level Notes

1 Any service in this family that used an anal tray required an equipment exception time to reflect the use of the tray in the post-op visits. Since all services were performed out of the office, the equipment exception time reflects the sum of the post-op visit time of the longest clinical staff type.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 872

Family 876 Deep Lymph Structure Procedures

Family-Level Notes

No family-level notes for family 876

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 876

Family 880 Spleen and Lymph Nodes

Family-Level Notes

No family-level notes for family 880

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 880

Family 884 Major Procedure - Endocrine

Family-Level Notes

1 Services in this family were grouped into benign and malignant cases which primarily served to establish the length of the first post-op visit. Benign services had a first post-op visit of 58 minutes while malignant services had a first post-op visit of 153 minutes. The type of service (benign or malignant) is indicated at the code level.

Procedure-Specific Notes

60200	*Remove thyroid lesion*	This service was profiled as typically benign.
60210	*Partial excision thyroid*	This service was profiled as typically benign.
60212	*Partial thyroid excision*	This service was profiled as typically benign.
60220	*Partial removal of thyroid*	This service was profiled as typically benign.
60225	*Partial removal of thyroid*	This service was profiled as typically benign.
60240	*Removal of thyroid*	This service was profiled as typically malignant.
60252	*Removal of thyroid*	This service was profiled as typically malignant.
60254	*Extensive thyroid surgery*	This service was profiled as typically malignant.
60260	*Repeat thyroid surgery*	This service was profiled as typically malignant.
60270	*Removal of thyroid*	This service was profiled as typically benign.
60271	*Removal of thyroid*	This service was profiled as typically benign.
60280	*Remove thyroid duct lesion*	This service was profiled as typically benign.
60281	*Remove thyroid duct lesion*	This service was profiled as typically benign.
60500	*Explore parathyroid glands*	This service was profiled as typically benign.
60502	*Re-explore parathyroids*	This service was profiled as typically benign.
60505	*Explore parathyroid glands*	This service was profiled as typically benign.
60520	*Removal of thymus gland*	This service was profiled as typically malignant.
60521	*Removal thymus gland*	This service was profiled as typically malignant.
60522	*Removal of thymus gland*	This service was profiled as typically malignant.

Famil, 884 (continued)

60540	*Explore adrenal gland*	This service was profiled as typically benign.
60545	*Explore adrenal gland*	This service was profiled as typically malignant.
60600	*Remove carotid body lesion*	This service was profiled as typically benign.

Family 888 Transplants

Family-Level Notes

1 The time associated with the G0 visit for all codes in the transplant family (with the exception of code 48554, a XXX global period) reflects 90 minutes of RN time that occurs only when the organ becomes available.

The panel provided clinical (G0) and administrative time (G2) to account for visits that occur during the waiting period prior to organ availability. However, these data were not incorporated into the data files.

The waiting period for liver services, (codes 47135, 47136, 48554, 50360, 50365), is typically 2 1/2 years. The visits during this time frame reflect the educational visits that are not billed separately as an evaluation and management service. During the 2 1/2 year waiting period codes 48554, 50360, and 50365 have 5 visits (1 visit every 6 months) , while codes 47135 and 47136 have 15 visits (1 visit every 2 months) .

The waiting period for the heart-lung transplant services, 32851, 32852, 32853, 32854, 33935, 33945, is typically 12 to 18 months with visits occurring every other month. During the waiting period, codes 32851, 32852, 33935, and 33945 typically have 7 visits while codes 32853 and 32854 typically have 10 visits. They are considered RN/PA teaching visits that could be surgical, shared, or medical. The practice costs associated with these visits are separate from the physician's visit. Even though there are other visits during this time that are separately billable evaluation and management services, typically a transplant physician does not bill a consult from the time the decision is made to do the procedure to the time of the procedure.

Details on the G0 visit and administrative times associated with these visits are provided for each code below. (These data are not included in the data files.)

Procedure-Specific Notes

32851 Lung transplant, single

# of G0 visits - 7

G0 : 420 minutes RN (60 minutes per visit)

G2: 210 minutes Insurance billing (30 minutes per visit)
210 minutes Medical secretary (30 minutes per visit)
210 minutes RN (30 minutes per visit)

The panel did not provide details on the supplies associated with these pre procedure visits.

32852 Lung transplant w/bypass

# of G0 visits - 7

G0 : 420 minutes RN (60 minutes per visit)

G2: 210 minutes Insurance billing (30 minutes per visit)
210 minutes Medical secretary (30 minutes per visit)
210 minutes RN (30 minutes per visit)

The panel did not provide details on the supplies associated with these pre procedure visits.

Family 888 (continued)

32853 Lung transplant, double

# of G0 visits - 10

G0 : 600 minutes RN (60 minutes per visit)

G2: 300 minutes Insurance billing (30 minutes per visit)
300 minutes Medical secretary (30 minutes per visit)
300 minutes RN (30 minutes per visit)

The panel did not provide details on the supplies associated with these pre procedure visits.

32854 Lung transplant w/bypass

# of G0 visits - 10

G0 : 600 minutes RN (60 minutes per visit)

G2: 300 minutes Insurance billing (30 minutes per visit)
300 minutes Medical secretary (30 minutes per visit)
300 minutes RN (30 minutes per visit)

The panel did not provide details on the supplies associated with these pre procedure visits.

33935 Transplantation, heart/lung

# of G0 visits - 7

G0 : 420 minutes RN (60 minutes per visit)

G2: 210 minutes Insurance billing (30 minutes per visit)
210 minutes Medical secretary (30 minutes per visit)
210 minutes RN (30 minutes per visit)

The panel did not provide details on the supplies associated with these pre procedure visits.

33945 Transplantation of heart

# of G0 visits - 7

G0 : 420 minutes RN (60 minutes per visit)

G2: 210 minutes Insurance billing (30 minutes per visit)
210 minutes Medical secretary (30 minutes per visit)
210 minutes RN (30 minutes per visit)

The panel did not provide details on the supplies associated with these pre procedure visits.

47135 Transplantation of liver

# of G0 visits - 15

Total G0 : 900 minutes RN (60 minutes per visit)

Total G2: 450 minutes Insurance billing (30 minutes per visit)
450 minutes Medical secretary (30 minutes per visit)
450 minutes RN (30 minutes per visit)

The panel did not provide details on the supplies associated with these pre procedure visits.

Family 888 (continued)

47136 Transplantation of liver

# of G0 visits - 15

Total G0 : 900 minutes RN (60 minutes per visit)

Total G2: 450 minutes Insurance billing (30 minutes per visit)
450 minutes Medical secretary (30 minutes per visit)
450 minutes RN (30 minutes per visit)

The panel did not provide details on the supplies associated with these pre procedure visits.

The panel profiled this service as if a living donor was typical.

48554 Transplantallograft pancreas

Even though this service has an XXX global period, the panel profiled it as a 90 day global, with 20 post-op and 28 length of stay visits. The times associated with the post-op visits and length of stay visits in the hospital were not incorporated in the data but are provided in detail below.

Total G0 - 90 minutes RN (there are no patient visits prior to the procedure only time required by the RN for preparation).

G1 - 640 minutes RN (28 length of stay visits in the hospital, 4 visits @ 40 minutes each in the ICU, and 24 visits @ 20 minutes each in the hospital)

G1.X - 200 minutes LPN (total time required for 20 post -op visits)
100 minutes Medical secretary (total time required for 20 post-op visits)
1260 minutes RN (total time required for 20 post-op visits)

The supply profile for the 20 post-op visits is identical to code 47136.

50360 Transplantation of kidney

# of G0 visits - 5

Total G0 : 300 minutes RN (60 minutes per visit)

Total G2: 150 minutes Insurance billing (30 minutes per visit)
150 minutes Medical secretary (30 minutes per visit)
150 minutes RN (30 minutes per visit)

The panel did not provide details on the supplies associated with these pre procedure visits.

50365 Transplantation of kidney

# of G0 visits - 5

Total G0 : 300 minutes RN (60 minutes per visit)

Total G2: 150 minutes Insurance billing (30 minutes per visit)
150 minutes Medical secretary (30 minutes per visit)
150 minutes RN (30 minutes per visit)

The panel did not provide details on the supplies associated with these pre procedure visits.

 DRAFT

Family 892 Tube Change

Family-Level Notes

No family-level notes for family 892

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 892

Family 896 Needle and Catheter Biopsy, Aspiration, Lavage and Intubation

Family-Level Notes

1 The panel profiled the G2 administrative time from the reference service for all services in this family. They noted that some of the RN time in the G2 may have been captured under clinical RN functions (G1). However, the panel opted to leave the entire RN administrative time at 65 minutes.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 896

Family 1116 Lower Gastrointestinal Endoscopy

Family-Level Notes

No family-level notes for family 1116

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1116

Family 1200 Minor Vascular Repair and Fistula Construction

Family-Level Notes

No family-level notes for family 1200

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1200

Family 1208 Major Vascular Procedures

Family-Level Notes

No family-level notes for family 1208

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1208

Family 1228 Major Procedure - Respiratory

Family-Level Notes

No family-level notes for family 1228

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1228

ID : E30020 Minor Surgical Tray

Total Price : $572 **Used by CPEP(s):** C 8

Components	*Price*
1oz shot glasses	N/A
Adson forceps	N/A
Allis clamp	N/A
Army navy retractor	N/A
Cutting stat	N/A
Foreps	N/A
Hemostat	N/A
Knife handle	N/A
Light source	N/A
Metzenbaum scissors	N/A
Needle driver	N/A
Senn retractor	N/A
Skin hooks	N/A
Suture scissors	N/A
Tray	N/A
Weitlanner retractor	N/A

CPEP 9: Otolaryngology

Notes for CPEP C 9

CPEP-Level Notes

All in-office procedure-specific equipment usage is based on the longest time of a clinical staff type in the procedure (G1) period, except where noted otherwise.

1 The panel's primary approach to profiling the services in this CPEP was two fold. First, G1 times were based on increases/decreases from the reference service, or the G1 time from the reference service was adjusted by using the Hsiao intra service time that was provided to the panel to assist with profiling. Second, post-op visit times were based on the panel's estimates of the required number of post op visits; the time per visit was derived from the post op visit profiles of the reference services.

2 The panel indicated that staff accompanied the physician to the hospital approximately 30 % of the time. The convention for collecting data when it was considered typical (greater than 50 %) for practice personnel to accompany the physician to the hospital was not established when the otolaryngology panel was held in May. Time estimates as provided by the panel are indicated in the G1 out setting. When there is 10 minutes in the G1 out setting associated with an RN/LPN/MA, this time represents staff time conducting follow-up phone calls in the office.

3 The panel stated that a G0 visit was typically used for out of office services that were elective.

4 "Equipment trays" were developed and assigned to specific codes. Please see attached appendix for lists of equipment contained in each of these equipment groupings.

5 For some 000 and 010 day global period services, the panel included a G0 visit.

Family 504 Complex Repair and Plastic Procedures of Eye

Family-Level Notes

No family-level notes for family 504

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 504

Family 700 Office Visits - New Patient

Family-Level Notes

1 The panel debated how to differentiate physician time from staff time. They discussed whether it was typical for their practice staff to assist in performing Level 3 services in the office setting.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 700

Family 704 Office Visits - Established Patient

Family-Level Notes

No family-level notes for family 704

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 704

Family 728 Consultation - Office

Family-Level Notes

No family-level notes for family 728

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 728

Family 884 Major Procedure - Endocrine

Family-Level Notes

No family-level notes for family 884

Procedure-Specific Notes

60512	*Autotransplant, parathyroid*	The panel profiled this ZZZ code with no clinical, administrative, supply, or equipment costs.

Family 900 Simple Facial Procedures (exc. nose and sinus)

Family-Level Notes

1 The panel grouped most of these services into fractures and excisions in order to assist with developing the resource profiles. Fracture codes do not have a G0 visit and staff did not accompany the physician to the hospital to assist with providing the service. Excision services typically had a G0 visit when the service was performed in the office and in the hospital setting, and staff accompanied the physician to the hospital approximately 30 % of the time.

Procedure-Specific Notes

21030	*Removal of face bone lesion*	This service was profiled as an excision code.
21031	*Remove exostosis, mandible*	This service was profiled as an excision code.
21040	*Removal of jaw bone lesion*	This service was profiled as an excision code.
21041	*Removal of jaw bone lesion*	This service was profiled as an excision code.
21044	*Removal of jaw bone lesion*	This service was profiled as an excision code.

Family 900 (continued)

21137	*Reduction of forehead*	This service was profiled as an excision code.
21315	*Treatment of nose fracture*	This service was profiled as a fracture code.
21320	*Treatment of nose fracture*	This service was profiled as a fracture code.
21325	*Repair of nose fracture*	This service was profiled as a fracture code.
21337	*Repair nasal septal fracture*	This service was profiled as a fracture code.
21355	*Repair cheek bone fracture*	This service was profiled as a fracture code.
21401	*Repair eye socket fracture*	This service was profiled as a fracture code.
21480	*Reset dislocated jaw*	This service was profiled as a fracture code.
21485	*Reset dislocated jaw*	This service was profiled as a fracture code.

Family 904 Complex Facial Procedures (exc. nose and sinus)

Family-Level Notes

1 The panel grouped this family of codes into impressions, grafts, hyoid fractures, TMJ, mandibles (fractures and non fractures), and Lefort services

Procedure-Specific Notes

21010	*Incision of jaw joint*	This service was classified in the TMJ subgroup.
21050	*Removal of jaw joint*	This service was classified in the TMJ subgroup.
21060	*Remove jaw joint cartilage*	This service was classified in the TMJ subgroup.
21070	*Remove coronoid process*	This service was classified in the TMJ subgroup.
21079	*Prepare face/oral prosthesis*	This service was classified in the impression subgroup.
21080	*Prepare face/oral prosthesis*	This service was classified in the impression subgroup.
21081	*Prepare face/oral prosthesis*	This service was classified in the impression subgroup.
21082	*Prepare face/oral prosthesis*	This service was classified in the impression subgroup.
21083	*Prepare face/oral prosthesis*	This service was classified in the impression subgroup.
21084	*Prepare face/oral prosthesis*	This service was classified in the impression subgroup.
21085	*Prepare face/oral prosthesis*	This service was classified in the impression subgroup.
21086	*Prepare face/oral prosthesis*	This service was classified in the impression subgroup.
21087	*Prepare face/oral prosthesis*	This service was classified in the impression subgroup.
21088	*Prepare face/oral prosthesis*	This service was classified in the impression subgroup.
21120	*Reconstruction of chin*	This service was classified in the mandible non fracture subgroup.

Family 904 (continued)

21121	*Reconstruction of chin*	This service was classified in the mandible non fracture subgroup.
21122	*Reconstruction of chin*	This service was classified in the mandible non fracture subgroup.
21123	*Reconstruction of chin*	This service was classified in the mandible non fracture subgroup.
21125	*Augmentation lower jaw bone*	This service was classified in the mandible non fracture subgroup.
21127	*Augmentation lower jaw bone*	This service was classified in the mandible non fracture subgroup.
21144	*Reconstruct midface, lefort*	This service was classified in the Lefort subgroup.
21145	*Reconstruct midface, lefort*	This service was classified in the Lefort subgroup.
21146	*Reconstruct midface, lefort*	This service was classified in the Lefort subgroup.
21147	*Reconstruct midface, lefort*	This service was classified in the Lefort subgroup.
21150	*Reconstruct midface, lefort*	This service was classified in the Lefort subgroup.
21151	*Reconstruct midface, lefort*	This service was classified in the Lefort subgroup.
21154	*Reconstruct midface, lefort*	This service was classified in the Lefort subgroup.
21155	*Reconstruct midface, lefort*	This service was classified in the Lefort subgroup.
21159	*Reconstruct midface, lefort*	This service was classified in the Lefort subgroup.
21160	*Reconstruct midface, lefort*	This service was classified in the Lefort subgroup.
21172	*Reconstruct orbit/forehead*	This service was classified in the Lefort subgroup.
21175	*Reconstruct orbit/forehead*	This service was classified in the Lefort subgroup.
21179	*Reconstruct entire forehead*	This service was classified in the Lefort subgroup.
21180	*Reconstruct entire forehead*	This service was classified in the Lefort subgroup.
21182	*Reconstruct cranial bone*	This service was classified in the Lefort subgroup.
21183	*Reconstruct cranial bone*	This service was classified in the Lefort subgroup.
21184	*Reconstruct cranial bone*	This service was classified in the Lefort subgroup.
21188	*Reconstruction of midface*	This service was classified in the Lefort subgroup.
21193	*Reconstruct lower jaw bone*	This service was classified in the mandible non fracture subgroup.
21194	*Reconstruct lower jaw bone*	This service was classified in the mandible non fracture subgroup.
21195	*Reconstruct lower jaw bone*	This service was classified in the mandible non fracture subgroup.
21196	*Reconstruct lower jaw bone*	This service was classified in the mandible non fracture subgroup.
21198	*Reconstruct lower jaw bone*	This service was classified in the mandible non fracture subgroup.
21206	*Reconstruct upper jaw bone*	This service was classified in the Lefort subgroup.

 DRAFT

Family 04 (continued)

21208	*Augmentation of facial bones*	This service was classified in the mandible non fracture subgroup.
21209	*Reduction of facial bones*	This service was classified in the mandible non fracture subgroup.
21210	*Face bone graft*	This service was classified in the graft subgroup.
21215	*Lower jaw bone graft*	This service was classified in the graft subgroup.
21230	*Rib cartilage graft*	This service was classified in the graft subgroup.
21235	*Ear cartilage graft*	This service was classified in the graft subgroup.
21240	*Reconstruction of jaw joint*	This service was classified in the TMJ subgroup.
21242	*Reconstruction of jaw joint*	This service was classified in the TMJ subgroup.
21243	*Reconstruction of jaw joint*	This service was classified in the TMJ subgroup.
21244	*Reconstruction of lower jaw*	This service was classified in the mandible non fracture subgroup.
21245	*Reconstruction of jaw*	This service was classified in the mandible non fracture subgroup.
21246	*Reconstruction of jaw*	This service was classified in the mandible non fracture subgroup.
21247	*Reconstruct lower jaw bone*	This service was classified in the TMJ subgroup.
21248	*Reconstruction of jaw*	This service was classified in the mandible non fracture subgroup.
21249	*Reconstruction of jaw*	This service was classified in the mandible non fracture subgroup.
21255	*Reconstruct lower jaw bone*	This service was classified in the Lefort subgroup.
21256	*Reconstruction of orbit*	This service was classified in the Lefort subgroup.
21260	*Revise eye sockets*	This service was classified in the Lefort subgroup.
21261	*Revise eye sockets*	This service was classified in the Lefort subgroup.
21263	*Revise eye sockets*	This service was classified in the Lefort subgroup.
21267	*Revise eye sockets*	This service was classified in the Lefort subgroup.
21268	*Revise eye sockets*	This service was classified in the Lefort subgroup.
21270	*Augmentation cheek bone*	This service was classified in the graft subgroup.
21275	*Revision orbitofacial bones*	This service was classified in the Lefort subgroup.
21280	*Revision of eyelid*	This service was classified in the Lefort subgroup.
21282	*Revision of eyelid*	This service was classified in the Lefort subgroup.
21295	*Revision of jaw muscle/bone*	This service was classified in the mandible non fracture subgroup.
21296	*Revision of jaw muscle/bone*	This service was classified in the mandible non fracture subgroup.
21330	*Repair of nose fracture*	This service was classified in the Lefort subgroup.

 DRAFT

Family 904 (continued)

21335	*Repair of nose fracture*	This service was classified in the Lefort subgroup.
21336	*Repair nasal septal fracture*	This service was classified in the Lefort subgroup.
21338	*Repair nasoethmoid fracture*	This service was classified in the Lefort subgroup.
21339	*Repair nasoethmoid fracture*	This service was classified in the Lefort subgroup.
21340	*Repair of nose fracture*	This service was classified in the Lefort subgroup.
21343	*Repair of sinus fracture*	This service was classified in the Lefort subgroup.
21344	*Repair of sinus fracture*	This service was classified in the Lefort subgroup.
21345	*Repair of nose/jaw fracture*	This service was classified in the mandible fracture subgroup.
21346	*Repair of nose/jaw fracture*	This service was classified in the mandible fracture subgroup.
21347	*Repair of nose/jaw fracture*	This service was classified in the Lefort subgroup.
21348	*Repair of nose/jaw fracture*	This service was classified in the Lefort subgroup.
21356	*Repair cheek bone fracture*	This service was classified in the Lefort subgroup.
21360	*Repair cheek bone fracture*	This service was classified in the Lefort subgroup.
21365	*Repair cheek bone fracture*	This service was classified in the Lefort subgroup.
21366	*Repair cheek bone fracture*	This service was classified in the Lefort subgroup.
21385	*Repair eye socket fracture*	This service was classified in the Lefort subgroup.
21386	*Repair eye socket fracture*	This service was classified in the Lefort subgroup.
21387	*Repair eye socket fracture*	This service was classified in the Lefort subgroup.
21390	*Repair eye socket fracture*	This service was classified in the Lefort subgroup.
21395	*Repair eye socket fracture*	This service was classified in the Lefort subgroup.
21406	*Repair eye socket fracture*	This service was classified in the Lefort subgroup.
21407	*Repair eye socket fracture*	This service was classified in the Lefort subgroup.
21408	*Repair eye socket fracture*	This service was classified in the Lefort subgroup.
21421	*Treat mouth roof fracture*	This service was classified in the mandible fracture subgroup.
21422	*Repair mouth roof fracture*	This service was classified in the mandible fracture subgroup.
21423	*Repair mouth roof fracture*	This service was classified in the Lefort subgroup.
21431	*Treat craniofacial fracture*	This service was classified in the Lefort subgroup.
21432	*Repair craniofacial fracture*	This service was classified in the Lefort subgroup.
21433	*Repair craniofacial fracture*	This service was classified in the Lefort subgroup.

Family 904 (continued)

21435	*Repair craniofacial fracture*	This service was classified in the Lefort subgroup.
21436	*Repair craniofacial fracture*	This service was classified in the Lefort subgroup.
21440	*Repair dental ridge fracture*	This service was classified in the mandible fracture subgroup.
21445	*Repair dental ridge fracture*	This service was classified in the mandible fracture subgroup.
21451	*Treat lower jaw fracture*	This service was classified in the mandible fracture subgroup.
21452	*Treat lower jaw fracture*	This service was classified in the mandible fracture subgroup.
21453	*Treat lower jaw fracture*	This service was classified in the mandible fracture subgroup.
21454	*Treat lower jaw fracture*	This service was classified in the mandible fracture subgroup.
21461	*Repair lower jaw fracture*	This service was classified in the mandible fracture subgroup.
21462	*Repair lower jaw fracture*	This service was classified in the mandible fracture subgroup.
21465	*Repair lower jaw fracture*	This service was classified in the mandible fracture subgroup.
21470	*Repair lower jaw fracture*	This service was classified in the mandible fracture subgroup.
21490	*Repair dislocated jaw*	This service was classified in the mandible fracture subgroup.
21493	*Treat hyoid bone fracture*	This service was classified in the hyoid fracture subgroup.
21494	*Repair hyoid bone fracture*	This service was classified in the hyoid fracture subgroup.
21495	*Repair hyoid bone fracture*	This service was classified in the hyoid fracture subgroup.
29800	*Jaw arthroscopy/surgery*	This service was classified in the TMJ subgroup.
29804	*Jaw arthroscopy/surgery*	This service was classified in the TMJ subgroup.
31225	*Removal of upper jaw*	This service was classified in the Lefort subgroup.
31230	*Removal of upper jaw*	This service was classified in the Lefort subgroup.
42280	*Preparation, palate mold*	This service was classified in the impression subgroup.
42281	*Insertion, palate prosthesis*	This service was classified in the impression subgroup.

 DRAFT

Family 908 Simple Nose and Sinus Procedures

Family-Level Notes

1 There was considerable discussion during the profiling of this family of services regarding the difference between the provision of office services by otolaryngologists and oral and maxillofacial surgeons, particularly with respect to the profiling of codes 31020 and 31030. Initially the panel determined that these two services should not be profiled in the office because it would be equivalent to a facility fee. Typically these services are performed in the hospital setting by otolaryngologists, and in the office setting by oral and maxillofacial surgeons. (The panel stated that only 10 % of these services are performed by oral and maxillofacial surgeons). The panel also discussed how an ENT physician in the office would set up an Ambulatory Surgical Center (which they said is not typical), and if they do not have an ASC then they would not perform this service. The panel opted to profile these services in both settings, leaving the policy decision to HCFA.

Procedure-Specific Notes

31020	*Exploration maxillary sinus*	Refer to the notes at the family level.
31030	*Exploration maxillary sinus*	Refer to the notes at the family level.

Family 912 Complex Nose and Sinus Procedures

Family-Level Notes

1 As discussed in family 908, the panel raised the question of whether codes 30120, 30580, and 30600 when performed in the office setting was equivalent to establishing a facility fee. The panel decided to profile these services in the hospital setting only.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 912

Family 916 Simple Ear Procedures

Family-Level Notes

No family-level notes for family 916

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 916

Family 920 Complex Ear Procedures

Family-Level Notes

1 50 % of physicians bring a mastoid tray to the hospital setting.

Procedure-Specific Notes

69720	*Release facial nerve*	This service required an equipment exception time to reflect the use of a hilger nerve stimulator in the post operative visits. The exception time was calculated as the sum of the maximum clinical staff type across all post operative visits.

Family 920 (continued)

69725	*Release facial nerve*	This service required an equipment exception time to reflect the use of a hilger nerve stimulator in the post operative visits. The exception time was calculated as the sum of the maximum clinical staff type across all post operative visits.
69740	*Repair facial nerve*	This service required an equipment exception time to reflect the use of a hilger nerve stimulator in the post operative visits. The exception time was calculated as the sum of the maximum clinical staff type across all post operative visits.
69745	*Repair facial nerve*	This service required an equipment exception time to reflect the use of a hilger nerve stimulator in the post operative visits. The exception time was calculated as the sum of the maximum clinical staff type across all post operative visits.
69955	*Release facial nerve*	This service required an equipment exception time to reflect the use of a hilger nerve stimulator in the post operative visits. The exception time was calculated as the sum of the maximum clinical staff type across all post operative visits.
69960	*Release inner ear canal*	This service required an equipment exception time to reflect the use of a hilger nerve stimulator in the post operative visits. The exception time was calculated as the sum of the maximum clinical staff type across all post operative visits.

Family 924 Cochlear Device Implantation

Family-Level Notes

No family-level notes for family 924

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 924

Family 928 Simple Oral and Pharyngeal Procedures

Family-Level Notes

1 The panel indicated that a G0 visit was not typical (only occurred 10 % of the time) for several services in this family. The codes that the panel said have a G0 visit 10 % of the time (requiring 70 minutes of an RN) are indicated at the code level, but are not included in the database.

Procedure-Specific Notes

41000	*Drainage of mouth lesion*	This service has a G0 visit 10 % of the time.
41005	*Drainage of mouth lesion*	This service has a G0 visit 10 % of the time.
41006	*Drainage of mouth lesion*	This service has a G0 visit 10 % of the time.
41007	*Drainage of mouth lesion*	This service has a G0 visit 10 % of the time.
41008	*Drainage of mouth lesion*	This service has a G0 visit 10 % of the time.
41009	*Drainage of mouth lesion*	This service has a G0 visit 10 % of the time.
41015	*Drainage of mouth lesion*	This service has a G0 visit 10 % of the time.
41016	*Drainage of mouth lesion*	This service has a G0 visit 10 % of the time.

Family 928 (continued)

41017	*Drainage of mouth lesion*	This service has a G0 visit 10 % of the time.
41018	*Drainage of mouth lesion*	This service has a G0 visit 10 % of the time.
41800	*Drainage of gum lesion*	This service has a G0 visit 10 % of the time.

Family 932 Complex Oral and Pharyngeal Procedures

Family-Level Notes

No family-level notes for family 932

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 932

Family 936 Salivary Gland and Duct Procedures

Family-Level Notes

No family-level notes for family 936

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 936

Family 940 Laryngeal and Tracheal Procedures

Family-Level Notes

1 For services in this family that are provided in the hospital setting, the panel applied a formula to account for the involvement of practice staff with length of stay visits (which require practice staff to accompany the physician to the hospital) and follow up phone calls in the office. The time requirements for the length of stay visits and phone calls are represented in the G1 out setting. Each length of stay visit required 20 minutes of RN time and each phone call required 17 minutes of RN time. This time represents an addition to the time that the staff accompanies the physician to assist with the procedure portion of the service. On average, each service in this family had 1-2 phone calls, or 17 to 34 minutes, of RN time attending to phone calls in the office. Exceptions to this are noted below.

2 Services in this family that used a flexible scope during the post - operative visits required an equipment exception time. The equipment exception time was calculated as the sum of the maximum clinical staff type used in all post-operative visits.

Procedure-Specific Notes

31600	*Incision of windpipe*	This service did not require additional time for length of stay visits or phone calls performed by physician staff.
31601	*Incision of windpipe*	This service did not require additional time for length of stay visits or phone calls performed by physician staff.
31603	*Incision of windpipe*	This service did not require additional time for length of stay visits or phone calls performed by physician staff.

Family 940 (continued)

31605	*Incision of windpipe*	This service did not require additional time for length of stay visits or phone calls performed by physician staff.

Family 944 Endoscopy of Upper Airway

Family-Level Notes

No family-level notes for family 944

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 944

Family 948 Other ENT Procedures

Family-Level Notes

No family-level notes for family 948

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 948

Family 952 Otorhinolaryngologic Function Tests

Family-Level Notes

No family-level notes for family 952

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 952

Family 956 Speech Therapy

Family-Level Notes

No family-level notes for family 956

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 956

Family 960 Simple Audiometry

Family-Level Notes

No family-level notes for family 960

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 960

ID : E72008 Septoplasty Tray

Total Price : $726 **Used by CPEP(s):** C 9

Components	*Price **
Bone rasps - 3	N/A
Elevators - 3	N/A
Forceps, Jansen, Middleton	N/A
Forceps, Takahashi	N/A
Forceps, bayonet	N/A
Knives	N/A
Mallet	N/A
Medicine glass - 2	N/A
Metal tray	N/A
Nasal specula - 2	N/A
Needle holders - 2	N/A
Osteotone - 4	N/A
Retractor	N/A
Scissors - 4	N/A
Skin hooks	N/A
Suctions - 3	N/A

** N/A = Not available.*

ID : E72012 Mastoid Tray

Total Price : $7,214 **Used by CPEP(s):** C 9

Components	*Price **
Alligators, small serrated - 2	N/A
Alligators, small smooth - 2	N/A
Annulus elevator	N/A
Bayonette, 2	N/A
Belucci scissors, large	N/A
Belucci scissors, small	N/A
Carol wall knife, round	N/A
Carol wall knife, stape	N/A
Cottle elevator	N/A
Cups forceps, large	N/A
Cups forceps, small - 3	N/A
Curettes, cerumen	N/A
Curettes, mastoid - 4	N/A
Curettes, stapes	N/A
Dental excavators	N/A
Ear speculae, metal - 6	N/A
Fascia press	N/A
Forceps, adson	N/A
Forceps, brown	N/A
Forceps, smooth	N/A

Hemostats, curved - 4	N/A
Knife handle	N/A
Lempert elevator	N/A
Medicine glasses - 2	N/A
Mosquito clamps - 2	N/A
Nasal speculum	N/A
Needle holder	N/A
Needles & adaptor	N/A
Periosteal elevator	N/A
Pick, rosen needle	N/A
Pick, straight	N/A
Scissors	N/A
Senn retractors - 2	N/A
Suction irrigators - 4	N/A
Suctions, 3 barons, 4 needles & adapter	N/A
Teflon block	N/A
Vein retractors	N/A
Weitlander retractors - 2	N/A

* *N/A = Not available.*

CPEP 10: Internal Medicine

Notes for CPEP C10

CPEP-Level Notes

All in-office procedure-specific equipment usage is based on the longest time of a clinical staff type in the procedure (G1) period, except where noted otherwise.

Family 704 Office Visits - Established Patient

Family-Level Notes

No family-level notes for family 704

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 704

Family 712 Hospital Visit - Subsequent

Family-Level Notes

No family-level notes for family 712

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 712

Family 724 Consultation - Inpatient

Family-Level Notes

No family-level notes for family 724

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 724

Family 896 Needle and Catheter Biopsy, Aspiration, Lavage and Intubation

Family-Level Notes

No family-level notes for family 896

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 896

 DRAFT

Family 1000 Introduction of Needle and Catheter

Family-Level Notes

No family-level notes for family 1000

Procedure-Specific Notes

64613 Destroy nerve, spine muscle This code has a 10 day global period. However, the panel said there are no post-operative visits associated with this code.

Family 1004 Spinal Tap

Family-Level Notes

No family-level notes for family 1004

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1004

Family 1008 Bone Marrow Procedures

Family-Level Notes

No family-level notes for family 1008

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1008

Family 1012 Allergy Tests

Family-Level Notes

1 The reference service, code 95024, is typically performed in groups of twelve, such that twelve skin tests are administered to the patient at one time. However, the panel decided to change the resource profile for this code so that it now reflects only one skin test. The fixed elements of cost (e.g. patient gown) that occur regardless of the number of skin tests are contained in their entirety in this profile. HCFA payment policy rules are necessary to accurately pay for multiple tests.

Procedure-Specific Notes

95070 Bronchial allergy tests Although this code was profiled in the out of office setting, there is no administrative time associated with its profile.

Family 1013 Simple Immunology Tests

Family-Level Notes

No family-level notes for family 1013

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1013

Family 1016 Allergy Immunotherapy

Family-Level Notes

1 Since the panel previously (in F. 1012) created a rule which states that codes should be profiled for one dose, the panel agreed to apply this rule to the reference service, code 95165, for this family as well. This service is typically performed in groups of ten doses. The fixed elements of cost (e.g. patient gown) that occur regardless of the number of skin tests are contained in their entirety in this profile. HCFA payment policy rules will be necessary to accurately pay for multiple tests.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1016

Family 1020 Immunotherapy

Family-Level Notes

No family-level notes for family 1020

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1020

Family 1024 Infusion Therapy except Chemotherapy

Family-Level Notes

No family-level notes for family 1024

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1024

Family 1028 Chemotherapy

Family-Level Notes

No family-level notes for family 1028

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1028

Family 1032 Blood and Transfusion

Family-Level Notes

No family-level notes for family 1032

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1032

Family 1036 Hemodialysis and Peritoneal Dialysis

Family-Level Notes

1 Reference service 90921 is a medical procedure that occurs over the course of a month. The service is always provided both in and out of the office. In order to reflect this in the code's resource profile, the panel profiled this code by putting the time needed to provide this service into the appropriate settings, in and out of the office. According to the panel member, the time spent delivering the service would appear as follows:

Code	Clinical in	Clinical out	Total clin	Admin in	Admin out	Total admin
90921	72	82	154	35	28	63
90918	102	82	184	35	28	63
90919	87	82	169	35	28	63
90920	72	82	154	35	28	63

These in office and out of office times do NOT indicate that the service is provided either in the office or out of the office. The service is always provided in both settings. The times, when taken together, reflect total service time and show where the service's components are delivered. For purposes of profiling this code and other codes which are delivered in the same way, it was determined that all the resources should be anchored to one setting. The labor data reflects the decision to anchor these resources to the out of office setting.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1036

Family 1040 Nerve and Muscle Tests

Family-Level Notes

No family-level notes for family 1040

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1040

Family 1044 Electroencephalogram

Family-Level Notes

No family-level notes for family 1044

Procedure-Specific Notes

95824 Electroencephalography	For this code, the in-office site was not profiled since the service is hospital-based. Some panelists indicated that the code is often paid technical component fees in the hospital setting, however currently the technical component is not reflected in its clinical resource profile. The panel provided an estimate of 15 minutes for the clinical time for this code for a technical component.
95955 EEG during surgery	Although this code was profiled in the in office setting, there is no clinical in office time associated with its profile. The clinical time for this code may increase when the technical component is added in, per HCFA. The panel provided an estimate of 153 minutes for the clinical time for the technical component for this service.

Family 1048 Extended EEG Studies

Family-Level Notes

No family-level notes for family 1048

Procedure-Specific Notes

95951 EEG monitoring/videorecord	According to the panel, reference service 95951 is typically billed in multiples of three or four. The panel agreed to "front load" the administrative time to reflect this typical billing pattern. The fixed elements of cost (e.g. patient gown) that occur regardless of the number of tests are contained in their entirety in this profile. HCFA payment policy rules will be necessary to accurately pay for multiple tests.

Family 1052 Respiratory Therapy

Family-Level Notes

No family-level notes for family 1052

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1052

Family 1056 Ventilator Management

Family-Level Notes

No family-level notes for family 1056

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1056

Family 1060 Endoscopy of the Lower Airway

Family-Level Notes

No family-level notes for family 1060

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1060

Family 1064 Pulmonary Services

Family-Level Notes

No family-level notes for family 1064

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1064

Family 1340 Exercise Tolerance Tests

Family-Level Notes

No family-level notes for family 1340

Procedure-Specific Notes

93016	*Cardiovascular stress test*	Although this code was profiled in the in office setting, there is no clinical in office time associated with its profile.
93018	*Cardiovascular stress test*	Although this code was profiled in the in office setting, there is no clinical in office time associated with its profile.

CPEP 11: Gastroenterology

Notes for CPEP C 1

CPEP-Level Notes

All in-office procedure-specific equipment usage is based on the longest time of a clinical staff type in the procedure (G1) period, except where noted otherwise.

Family 704 Office Visits - Established Patient

Family-Level Notes

1 The G1 out-of-office clinical staff times (7 minutes) for HCPCS codes 99211, 99212, 99214, and 99215 in Family 704 reflect time that office staff spend on post-service activities related to reviewing patient reports and responding to calls from the patient when these services are done in an out-of-office setting.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 704

Family 712 Hospital Visit - Subsequent

Family-Level Notes

1 According to the panel, HCPCS codes 99217-99357 require office staff to spend time on post-service activities related to reviewing patient reports and responding to calls from the patient. Therefore, the panel included 7 minutes of the RN/LPN staff type in the G1 out-of-office category to reflect time spent on these activities.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 712

Family 724 Consultation - Inpatient

Family-Level Notes

1 The G1 out-of-office clinical staff times (7 minutes) for HCPCS codes 99251-99255 (initial inpatient consultation) and HCPCS codes 99271-99275 (confirmatory consultation) denote time that office staff spend reviewing patient reports and responding to calls from the patient in post-service period.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 724

Family 728 Consultation - Office

Family-Level Notes

No family-level notes for family 728

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 728

Family 1100 Alimentary Tests and Simple Tube Placement

Family-Level Notes

1 In completing this family, the panel organized the codes into the following categories of procedure types: gastric analysis, intubation, motility studies, and perfusion.

Gastric Analysis	Intubation	Motility Studies	Perfusion
89135	44500	91010	91030
89136	91000	91011	91032
89140	89100	91012	91033
89141	89105	91020	
91052	89130		
	89132		
	91055		

With respect to the in-office times, the first code in each group was compared to the reference service and the subsequent codes within each category were adjusted accordingly. The panel explained that the variation in the total in-office times for these codes was due solely to variation in the time required to perform intra-service functions; the pre- and post-service times were considered consistent across all codes.

The out-of-office clinical staff times for the HCPCS codes in this family reflect time that office staff spend on pre- and post-service activities. HCPCS codes 44500-91100 were all considered equivalent to the reference service (HCPCS 91010) out-of-office times. The out-of-office reference service times were allocated as follows: 10 minutes on pre-service functions for educating the patient and preparing medical charts and 5 minutes on post-service functions for reviewing results of procedure and responding to calls from the patient. Five minutes were deducted from the pre-service out-of-office time for 91105.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1100

Family 1104 Esophageal Dilation without Endoscopy

Family-Level Notes

1 According to the panel, when HCPCS codes in Family 1104 are performed out of the office, office staff spend time on pre- and post-service activities. Therefore, the panel included the time required to complete these activities in the G1 out-of-office time. Each of the out-of-office times for the codes in this family were considered equivalent to the reference service (HCPCS 91010) out-of-office times, which were allocated as follows: 10 minutes on pre-service functions for educating the patient and preparing records and 5 minutes on post-service functions for reviewing results and responding to calls from the patient.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1104

Family 1108 Diagnostic Upper GI Endoscopy or Intubation

Family-Level Notes

1 The G1 out-of-office clinical staff times for the HCPCS codes in this family reflect time that office staff spend on pre- and post-service activities. The out-of-office times for HCPCS codes 43200, 43202, 43234, 43235, 43600, and 44100 were considered equivalent to the reference service (HCPCS 43239) out-of-office times, which were recorded as follows: 35 minutes on pre-service functions for educating the patient, describing reasons for conducting procedure, and preparing records, as well as 10 minutes on post-service functions for reviewing charts and responding to calls from the patient. Ten minutes were added to the pre-service times for 43259, 44360, and 44361 because these procedures are more complicated and require more patient education prior to the procedure (in addition to the final patient education immediately before the procedure). In addition, the panel thought that advances in medical technology have allowed HCPCS codes 43235 and 43239 to be conducted more frequently in the office

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1108

Family 1112 Therapeutic Upper GI Endoscopy or Intubation

Family-Level Notes

1 The G1 out-of-office clinical staff times for the HCPCS codes in these families reflect time that office staff spend on pre- and post-service activities (i.e., preparing charts, educating patient, and responding to calls from patient). The GI times do not include time associated with intra-service functions.

Procedure-Specific Notes

43750 Place gastrostomy tube	The panel indicated that this code should not have a global period because it is used to bill for services rendered by an assistant to an endoscopist. It is billed in conjunction with HCPCS 43246.

Family 1116 Lower Gastrointestinal Endoscopy

Family-Level Notes

No family-level notes for family 1116

Procedure-Specific Notes

45355 Surgical colonoscopy	The panel did not profile HCPCS 45355 because it is done primarily by general surgeons or colorectal surgeons.

Family 1120 Anoscopy

Family-Level Notes

1 The G1 in-office clinical times for the codes in this family were consistently greater than the clinical time for the reference service. The panel confirmed that the reference service was simpler relative to all of the other codes and required less time.

Procedure-Specific Notes

46220 Removal of anal tab	Based on the information provided by the panel, there are no post-procedure visits associated with HCPCS code 46220. Therefore, the clinical and administrative staff times for these visits equal 0.

Family 1124 Proctosigmoidoscopy and Sigmoidoscopy

Family-Level Notes

1 In completing this family, the panel organized the codes into diagnostic and therapeutic categories as follows:

Diagnostic	Therapeutic		
45300	45303	45320	45338
45305	45307	45321	45339
45330	45308	45332	
45331	45309	45333	
	45315	45334	
	45317	45337	

With respect to the in-office times, the first code in each group was compared to the reference service and the subsequent codes within each category were adjusted as appropriate. In general, although this was not the case for each therapeutic code, the panel said that therapeutic codes require more time than diagnostic codes because there is more bleeding.

As explained by the panel, the G1 out-of-office clinical staff times for the HCPCS codes in this family reflect time that office staff spend on pre- and post-service activities. Each of the codes was considered equivalent to the reference service (HCPCS 45330) out-of-office times. The out-of-office reference service times were allocated as follows: 5 minutes on pre-service functions for preparing charts and educating the patient and 10 minutes on post-service functions for reviewing results of procedure and responding to calls from the patient.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1124

Family 1128 ERCP and Miscellaneous GI Endoscopy Procedures

Family-Level Notes

1 G1 out-of-office clinical staff times for the HCPCS codes in this family denote time that office staff spend preparing records/educating the patient in the pre-procedure period and reviewing the results of procedure and responding to patient phone calls in the post-procedure period. The out-of-office times for these codes were considered equivalent to the reference service (HCPCS 43260) out-of-office times: 18 minutes on pre-service functions and 20 minutes on post-service functions.

Procedure-Specific Notes

47510	*Insert catheter, bile duct*	Based on the information provided by the panel, there are no post-procedure visits associated with HCPCS code 47510. Therefore, the clinical and administrative staff times for these visits equal 0.
47511	*Insert bile duct drain*	Based on the information provided by the panel, there are no post-procedure visits associated with HCPCS code 47511. Therefore, the clinical and administrative staff times for these visits equal 0.
47630	*Remove bile duct stone*	Based on the information provided by the panel, there are no post-procedure visits associated with HCPCS code 47630. Therefore, the clinical and administrative staff times for these visits equal 0.

CPEP 12:
Cardiothoracic & Vascular

Notes for CPEP C12

CPEP-Level Notes

All in-office procedure-specific equipment usage is based on the longest time of a clinical staff type in the procedure (G1) period, except where noted otherwise.

1 All G1 out of office clinical staff times only occur when staff accompany the physician to the hospital. The panel did not indicate that any of the clinical G1 out of office time was occurring in the physicians office.

2 The panel made G0 time estimates, that reduced or removed the GO component from the code's staff times when they believed a code to be emergent .

3 The staff types the panel stated they brought with them to hospital were:

RN/LPN/PA/Other
PA
Scrub Nurse
Perfusionist
PA/NP
RN

4 The panel stated that they understood that the PA can sometimes bill separately and were instructed not to include the PA time when they believed this to be the case.

5 The panel frequently drew on estimates of service from several families to profile codes in a family. The panel used reference services, as well as other profiled codes, from throughout the CPEP 12 data as base times for completing other codes within the CPEP, particularly in families 1200, 1204, 1208, and 1212. There was no formula or pattern to the panel's use of reference service times. The choice of base times came about through panel discussion, as to which codes involved similar staff times. This was true of both the clinical and administrative components of the codes.

6 For some 000 and 010 day global period services, the panel included a G0 visit.

Family 704 Office Visits - Established Patient

Family-Level Notes

1 The panel indicated that more administrative time is required for out-of-office visits than for in-office visits.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 704

Family 724 Consultation - Inpatient

Family-Level Notes

1 The panel indicated that more administrative time is required for out-of-office visits than for in-office visits.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 724

Family 728 Consultation - Office

Family-Level Notes

No family-level notes for family 728

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 728

Family 812 Esophagus

Family-Level Notes

1 The panel added or subtracted 30 minutes of an RN and PA in the G1 period for each day added to, or subtracted from, the length of stay in the hospital. No reference was made to length of stay affecting administrative time. All of these groups of codes used their families' reference service as their primary reference service.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 812

Family 816 Diaphragm

Family-Level Notes

1 The panel added or subtracted 30 minutes of an RN and PA in the G1 period for each day added to, or subtracted from, the length of stay in the hospital. No reference was made to length of stay affecting administrative time. All of these groups of codes used their families' reference service as their primary reference service.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 816

Family 1060 Endoscopy of the Lower Airway

Family-Level Notes

No family-level notes for family 1060

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1060

Family 1200 Minor Vascular Repair and Fistula Construction

Family-Level Notes

No family-level notes for family 1200

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1200

Family 1204 Vascular Ligation

Family-Level Notes

No family-level notes for family 1204

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1204

Family 1208 Major Vascular Procedures

Family-Level Notes

1 No consistently used reference service for the codes in this family.

Procedure-Specific Notes

35681	*Artery bypass graft*	Although this is coded as a ZZZ code the panel stated that this is a separate and complete procedure. There was no objection from the HCFA representatives, thus the data were recorded as a separate global procedure with 5 post operative visits.
35700	*Reoperation, bypass graft*	Although this is coded as a ZZZ code, the panel states that this is a re-operation. The panel provided data for a complete procedure with 5 post operative visits. HCFA did not object to the profile provided by the panel, thus the data were entered as reported by the panel.
35820	*Explore chest vessels*	The panel reported zero post-op visits for this code.
36834	*Repair A-V aneurysm*	The panel reported zero post-op visits for this code.

Family 1212 Removal and Revision of Vascular Devices

Family-Level Notes

No family-level notes for family 1212

Procedure-Specific Notes

36532	*Removal of infusion pump*	The panel reported zero post-op visits for this code.
36534	*Revision of access port*	The panel reported zero post-op visits for this code.

Family 1216 Heart and Great Vessels

Family-Level Notes

1 The panel added or subtracted 30 minutes of an RN and PA in the G1 period for each day added to, or subtracted from, the length of stay in the hospital. The panel stated that each additional 3 days length of stay, beyond the first 3 days, required an additional 30 minutes of Insurance/Billing staff in the G2 period to obtain insurer approval for the additional 3 days length of stay.

2 Primary reference service used for these codes: 33405 - Replacement of Aortic Valve

Procedure-Specific Notes

33350	*Repair major blood vessel(s)*	The panel reported zero post op. visits for this code.
33973	*Insert balloon device*	Panel treated this code as a ZZZ code.

Family 1220 CABG

Family-Level Notes

1 For codes - 33517, 33519, 33521, 33522, and 33523
Primary reference service is: 33518 - Coronary Artery Bypass...Two Venous Grafts...List Separately

2 Primary reference service used for the remainder of codes in Family 1220: 33533 - Coronary Artery Bypass...Single Arterial Graft

Procedure-Specific Notes

33517	*CABG, artery-vein, single*	Panel treated this code as a ZZZ code.
33518	*CABG, artery-vein, two*	Panel treated this code as a ZZZ code.
33519	*CABG, artery-vein, three*	Panel treated this code as a ZZZ code.
33521	*CABG, artery-vein, four*	Panel treated this code as a ZZZ code.
33522	*CABG, artery-vein, five*	Panel treated this code as a ZZZ code.
33523	*CABG, artery-vein, six+*	Panel treated this code as a ZZZ code.
33530	*Coronary artery, bypass/reop*	The panel reported zero post-op visits for this code.

Family 1224 Pediatric Cardiovascular Procedures

Family-Level Notes

1 The panel added or subtracted 30 minutes of an RN and PA in the G1 period for each day added to, or subtracted from, the length of stay in the hospital. The panel stated that each additional 3 days length of stay, beyond the first 3 days, required an additional 30 minutes of Insurance/Billing staff in the G2 period to obtain insurer approval for the additional 3 days length of stay.

Procedure-Specific Notes

33698	*Repair of heart defects*	The panel reported zero post op. visits for this code.

Family 1228 Major Procedure - Respiratory

Family-Level Notes

1 The panel added or subtracted 30 minutes of an RN and PA in the G1 period for each day added to, or subtracted from, the length of stay in the hospital. The panel stated that each additional 3 days length of stay, beyond the first 3 days, required an additional 30 minutes of Insurance/Billing staff in the G2 period to obtain insurer approval for the additional 3 days length of stay.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1228

Family 1232 Thoracoscopy

Family-Level Notes

1 The panel added or subtracted 30 minutes of an RN and PA in the G1 period for each day added to, or subtracted from, the length of stay in the hospital. The panel stated that each additional 3 days length of stay, beyond the first 3 days, required an additional 30 minutes of Insurance/Billing staff in the G2 period to obtain insurer approval for the additional 3 days length of stay.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1232

Family 1312 Angioplasty and Transcatheter Procedures, other than Coronary

Family-Level Notes

1 Resource profiles for services in this family were provided by one CPEP member after the round 2 meetings, as part of follow up activities. Although the information provided included staff time for post-operative visits, the time for the post-operative visits was not included as part of the data set because the post operative visits are separately billable services. Removing the post-operative visits for these services is consistent with treatment for other '000' global period services in this CPEP.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1312

Family 1320 Pacemaker Insertion

Family-Level Notes

1 The panel added or subtracted 30 minutes of an RN and PA in the G1 period for each day added to, or subtracted from, the length of stay in the hospital. No reference was made to length of stay affecting administrative time. All of these groups of codes used their families' reference service as their primary reference service. Primary reference service for these families are as originally assigned unless noted otherwise.

Procedure-Specific Notes

33243	*Remove generator/thoracotomy*	The panel reported zero post-op visits for this code.

CPEP 13: Cardiology

Notes for CPEP C13

CPEP-Level Notes

All in-office procedure-specific equipment usage is based on the longest time of a clinical staff type in the procedure (G1) period, except where noted otherwise.

1 The panel's predominate method of profiling services was to construct individual profiles for each code. The panel did not draw on formulae, or on references to profiles of other services.

2 The panel stated that the out of office clinical time only occurred when staff accompanied the physician to the hospital.

3 The panel indicated that in their judgement, it was typical for cardiology practices to use clinical practice staff in out-of-office settings. The clinical time estimates in the G1 period reflect the use of these practice staff in the out-of-office setting in which the service is performed.

4 The out-of-office supply profiles typically include educational pamphlets that are given to patients.

Family 636 Nuclear Cardiology

Family-Level Notes

No family-level notes for family 636

Procedure-Specific Notes

78478 *Heart wall motion (add-on)* Panel treated this code as a ZZZ code.

78480 *Heart function, (add-on)* Panel treated this code as a ZZZ code.

Family 704 Office Visits - Established Patient

Family-Level Notes

No family-level notes for family 704

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 704

Family 712 Hospital Visit - Subsequent

Family-Level Notes

No family-level notes for family 712

Procedure-Specific Notes

99357 *Prolonged service, inpatient* Panel treated this code as a ZZZ code.

Family 724 Consultation - Inpatient

Family-Level Notes

No family-level notes for family 724

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 724

Family 728 Consultation - Office

Family-Level Notes

No family-level notes for family 728

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 728

Family 1300 Placement of Transvenous Catheters

Family-Level Notes

No family-level notes for family 1300

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1300

Family 1304 Diagnostic Cardiac Catheterization

Family-Level Notes

1 Panel provided a general note that the drivers for this family were:

Patient education (for the pre and post periods)
Difficulty of the procedure (for the intra period)

Procedure-Specific Notes

76932	*Echo guide for heart biopsy*	Panel assigned zero to both the clinical an administrative times for this code.
93539	*Injection, cardiac cath*	Panel treated these codes as ZZZ codes.
93540	*Injection, cardiac cath*	Panel treated these codes as ZZZ codes.
93541	*Injection for lung angiogram*	Panel treated these codes as ZZZ codes.
93542	*Injection for heart x-rays*	Panel treated these codes as ZZZ codes.
93543	*Injection for heart x-rays*	Panel treated these codes as ZZZ codes.

Family 1304 (continued)

93544	*Injection for aortography*	Panel treated these codes as ZZZ codes.
93545	*Injection for coronary xrays*	Panel treated these codes as ZZZ codes.
93555	*Imaging, cardiac cath*	Panel treated these codes as ZZZ codes.
93556	*Imaging, cardiac cath*	Panel treated these codes as ZZZ codes.
93562	*Cardiac output measurement*	Panel treated these codes as ZZZ codes.

Family 1308 Coronary Angioplasty

Family-Level Notes

1 Panel stated that the reference service is the simplest of the angioplasty procedures.

2 Panel stated that the RN involved in the procedures in this family is the at the highest level of skill and salary for RNs.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1308

Family 1312 Angioplasty and Transcatheter Procedures, other than Coronary

Family-Level Notes

1 The panel provided the following formula for the codes profiled in this family.

All 70000 (except 75978, 75992, 75993) codes as ZZZ codes (no additional clinical or administrative time)

All other codes: 80% of code 92982 clinical time; 100% of code 92982 administrative time.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1312

Family 1316 Resuscitation and Cardioversion

Family-Level Notes

No family-level notes for family 1316

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1316

Family 1320 Pacemaker Insertion

Family-Level Notes

1 Panel provided a general note that the drivers for this family were:

Patient education (for the pre and post periods)
Difficulty of the procedure (for the intra period)

2 The equipment exception time for this family defaults to the G1X time. This is equipment used to adjust the patient pacemaker during the post op. visits.

Procedure-Specific Notes

71090	*X-ray & pacemaker insertion*	Panel treated this code as a ZZZ code.

Family 1324 Cardiac Rehabilitation

Family-Level Notes

No family-level notes for family 1324

Procedure-Specific Notes

93797	*Cardiac rehab*	Panel assigned zero clinical and administrative staff time to this code.
93798	*Cardiac rehab/monitor*	Panel assigned zero clinical and administrative staff time to this code.

Family 1332 Cardiogram

Family-Level Notes

No family-level notes for family 1332

Procedure-Specific Notes

93012	*Transmission of ecg*	Panel stated this code is for multiple recordings over a 30 day period. Panel assumed 10 recordings per month.
93014	*Report on transmitted ecg*	Panel assigned zero clinical and administrative staff time to this code.

Family 1336 Echocardiography

Family-Level Notes

No family-level notes for family 1336

Procedure-Specific Notes

93320	*Doppler echo exam, heart*	Panel treated this code as a ZZZ code.
93321	*Doppler echo exam, heart*	Panel treated this code as a ZZZ code.
93325	*Doppler color flow*	Panel treated this code as a ZZZ code.

Family 1340 Exercise Tolerance Tests

Family-Level Notes

No family-level notes for family 1340

Procedure-Specific Notes

93024	*Cardiac drug stress test*	Panel treated this code as a ZZZ.

Family 1344 Minor Cardiac and Vascular Tests

Family-Level Notes

No family-level notes for family 1344

Procedure-Specific Notes

93204	*Phonocardiogram & ECG lead*	Panel assigned zero clinical and administrative staff time to this code.
93209	*Special phonocardiogram*	Panel assigned zero clinical and administrative staff time to this code.
93210	*Intracardiac phonocardiogram*	Panel member treated this code as a ZZZ code.
93227	*ECG monitor/review, 24 hrs*	Panel assigned zero clinical and administrative staff time to this code.
93233	*ECG monitor/review, 24 hrs*	Panel assigned zero clinical and administrative staff time to this code.
93237	*ECG monitor/review, 24 hrs*	Panel assigned zero clinical and administrative staff time to this code.
93268	*ECG record/review*	Panel stated this is for multiple recordings over a 30 day period. Panel assumed 10 recordings per month.
93270	*ECG recording*	Panel stated this is for multiple recordings over a 30 day period. Panel assumed 10 recordings per month.
93271	*ECG/monitoring and analysis*	Panel stated this is for multiple recordings over a 30 day period. Panel assumed 10 recordings per month.
93272	*ECG/review interpret only*	Panel stated this is for multiple recordings over a 30 day period. Panel assumed 10 recordings per month. Panel assigned zero clinical and administrative staff time to this code.
G0004	*ECG transm phys review & int*	Panel stated this is for multiple recordings over a 30 day period. Panel assumed 10 recordings per month.
G0007	*ECG phy review & interpret*	Panel assigned zero clinical and administrative staff time to this code.
G0016	*Post symptom ECG md review*	Panel stated this is for multiple recordings over a 30 day period. Panel assumed 10 recordings per month. Panel assigned zero clinical and administrative staff time to this code.

Family 1348 Pacemaker Analysis

Family-Level Notes

1 Panel provided a general note that the drivers for this family were:

Patient education (for the pre and post periods)
Difficulty of the procedure (for the intra period)

2 Panel stated that they believed that the out of office site of service reported for codes in this family by the BMAD data is incorrect. They suspect miscoding.

3 Panel stated that the reference service for this family represents the simplest of these codes.

Procedure-Specific Notes

93731	*Analyze pacemaker system*	Panel was uncertain how often this code was billed with an E&M code. In cases where an E & M service was provided, the panel stated that the Medical Secretary and Medical Records staff time should be reduced. They did not provide the amount of time it should be reduced. Panel stated that this code did not involve programming
93732	*Analyze pacemaker system*	Panel was uncertain how often this code was billed with an E&M code. In cases where an E & M service was provided, the panel stated that the Medical Secretary and Medical Records staff time should be reduced. They did not provide the amount of time it should be reduced.
93734	*Analyze pacemaker system*	Panel was uncertain how often this code was billed with an E&M code. In cases where an E & M service was provided, the panel stated that the Medical Secretary and Medical Records staff time should be reduced. They did not provide the amount of time it should be reduced. Panel stated that this code did not involve programming
93735	*Analyze pacemaker system*	Panel was uncertain how often this code was billed with an E&M code. In cases where an E & M service was provided, the panel stated that the Medical Secretary and Medical Records staff time should be reduced. They did not provide the amount of time it should be reduced.

Family 1352 Cardiac Electrophysiologic Tests

Family-Level Notes

1 Panel provided a general note that the drivers for this family were:

Patient education (for the pre and post periods)
Difficulty of the procedure (for the intra period)

Procedure-Specific Notes

93623	*Stimulation, pacing heart*	Panel assigned zero administrative staff time for this code.

CPEP 14:
Anesthesia & Pathology

Notes for CPEP C14

CPEP-Level Notes

All in-office procedure-specific equipment usage is based on the longest time of a clinical staff type in the procedure (G1) period, except where noted otherwise.

1 Pathology services: Families 1400, 1404, 1408, 1412, 1416, 1420

The panel indicated that all services could be performed in both an independent laboratory or hospital based laboratory setting. Resources used in independent laboratories were profiled in the in-office setting; hospital based laboratories were profiled in the out-of-office setting. The primary factor differentiating these sites is that clinical functions in the hospital based setting are performed typically by hospital based personnel. (The physician practice would only bill for the professional component of the service in the hospital based laboratory setting). Thus, the labor profiles for the hospital setting do not reflect time for clinical practice support personnel. Administrative profiles for the provision of the service in both sites were collected and are for the most part identical.

Supply and equipment profiles for services performed in an independent laboratory were provided by the panel. (The costs assumed with the provision of the service in a hospital based laboratory are covered by the hospital under Medicare Part A. The panel indicated that it was not typical for any supplies or equipment to be paid for by the practice when they performed the service in a hospital based laboratory setting.)

During the panel meeting, the panel members were able to provide supply profiles for the majority of pathology services in the CPEP. Typical supply amounts and more detailed supply descriptions were provided by two panel members on a "homework assignment" from the panel. (The panel members had difficulty providing typical amounts and complete supply profiles during the meeting).

The panel members stated that each service required administrative supplies such as requisition forms, billing forms, and report forms. However, since the scope of data collection for supplies only includes clinical supplies, these administrative costs were not included as part of the services costing profile.

Family 716 Hospital Visit - Critical Care

Family-Level Notes

No family-level notes for family 716

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 716

Family 1400 Pathology

Family-Level Notes

No family-level notes for family 1400

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1400

Family 1404 Complex Pathology

Family-Level Notes

1 Several panelists noted that it was very difficult to profile some of the codes in this family because of the difficulty in defining a typical scenario.

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1404

Family 1408 Surgical Pathology

Family-Level Notes

No family-level notes for family 1408

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1408

Family 1412 Cytopathology

Family-Level Notes

No family-level notes for family 1412

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1412

Family 1416 Pap Smears

Family-Level Notes

No family-level notes for family 1416

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1416

Family 1420 Special Stains

Family-Level Notes

No family-level notes for family 1420

Procedure-Specific Notes

Family 1420 (continued)

88312	*Special stains*	The panel stated that the reference service for this family of services was profiled as automated, however this service is not typically automated. Automation for this service depends on the size of the practice and the volume of work being performed Since this service involves micro-organism staining, the panel first attempted to develop a profile that represented an average of different techniques. Eventually, the panel reached a profile that they established as a typical service.
88313	*Special stains*	The panel stated that the reference service for this family of services was profiled as automated, however this service is not typically automated. Automation for this service depends on the size of the practice and the volume of work being performed.

Family 1428 Anesthesia

Family-Level Notes

1 The panel applied a consistent method of profiling the services in this family based on changes from the reference service. These changes (additions or subtraction of time) were to reflect differing time requirements due to procedure set-up and positioning of the patient.

2 It was pointed out to the panel that staff employed by the hospital and staff performing billable physician work (e.g. CRNA's) are not included as practice expense. The panel indicated that estimates of clinical staff in the office setting were clinical staff employed by the practice who were conducting support activities.

Procedure-Specific Notes

00104	According to BMAD data, this service is performed in the office more than 10 % of the time. However, the panel reported that these BMAD data may reflect coding errors relative to the site of service. The panel decided to profile the service in both the office and in the hospital.
00124	According to BMAD data, this service is performed in the office more than 10 % of the time. It was not clear from this data whether the % volume in the office can be attributed to errors in claims data. The panel decided to profile the service both in the office and in the hospital.

Family 1432 Other Anesthesia Services

Family-Level Notes

1 The panel profiled the services in this family by following the expected sites of service as indicated by BMAD volume data. The panel indicated that the estimates of clinical staff time in both the office and hospital setting were identical. Staff times in the hospital setting reflect support activities of clinical staff employed by the physician's practice.

Procedure-Specific Notes

62280	*Treat spinal cord lesion*	Even though this service has a 10 day global period, the panel did not provide post operative visit information.
62281	*Treat spinal cord lesion*	Even though this service has a 10 day global period, the panel did not provide post operative visit information.
62282	*Treat spinal canal lesion*	Even though this service has a 10 day global period, the panel did not provide post operative visit information.
64620	*Injection treatment of nerve*	Even though this service has a 10 day global period, the panel did not provide post operative visit information.

Family 1432 (continued)

64622	*Injection treatment of nerve*	Even though this service has a 10 day global period, the panel did not provide post operative visit information.
64630	*Injection treatment of nerve*	Even though this service has a 10 day global period, the panel did not provide post operative visit information.
64640	*Injection treatment of nerve*	Even though this service has a 10 day global period, the panel did not provide post operative visit information.
64680	*Injection treatment of nerve*	Even though this service has a 10 day global period, the panel did not provide post operative visit information.

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CPEP 15: Neurosurgery

Notes for CPEP C15

CPEP-Level Notes

All in-office procedure-specific equipment usage is based on the longest time of a clinical staff type in the procedure (G1) period, except where noted otherwise.

1 The panel determined that the majority of services performed by neurosurgeons are only done in a hospital setting. Even when the BMAD data suggested that the services could be done in the office (fell within the 10 % rule) the panel opted to only profile the service out of the office.

2 The panel indicated that use of practice personnel in the G1 out clinical period is becoming typical. The factors that contribute to whether physicians bring their own staff to the hospital is the size of the practice (e.g. typically a practice with greater than 4 physicians) and the geographic location of the practice.

3 G1 intra -The panel primarily used the Hsiao intra times (according the Hsiao Phase III study) as a key driver for distinguishing labor times associated with the intra or procedure portion of the service. The intra-service physician time according to the RUC review for neurosurgery services was also made available at the meetings by one of the CPEP members.

The guidelines for determining procedure times were as follows:

a). If the Hsiao intra time was less than 60 minutes, then the total procedure time (equivalent to G1) was equal to the Hsiao intra time multiplied by 2. Half of the total time was equivalent to the time of the surgical assistant during the intra period of the procedure. The other half of the total time represented the post procedure time (G1 post) which was to be split between the following staff types: 1/3 RN and 2/3 RN/LPN/MA.

b). If the Hsiao intra time was greater than 60 minutes, then the Hsiao time was used for the surgical assistant during the intra procedure portion of the service and the post procedure time (G1 post) was equivalent to the 60 minute base from the reference service, and was split between the following staff types, 1/3 RN and 2/3 RN/LPN/MA. Any additional time increment beyond the 60 minute G1 post reference service base was to account for the provision of more complicated services and was also split 1/3 RN and 2/3 RN/LPN/MA.

4 G1 - post: The majority of codes in the CPEP have time allocated in the following ratio in the G1: 1/3 RN to 2/3 RN/LPN/MA. The times were taken either directly from the reference service (which typically had 60 minutes post allocated 20 minutes to an RN and 40 minutes to an RN/LPN/MA) or the times represent one of the Hsiao times divided 1/3 to an RN and 2/3 to an RN/LPN/MA. According to the "building block code", code 63030, which was profiled in detail during the February meetings and was used as the standard for profiling the majority of reference services in the CPEP, the 60 minutes that occurs in G1 post (20 minutes of an RN and 40 minutes of an RN/LPN/MA) reflects 20 min of an RN arranging discharge, 20 minutes of an RN/LPN/MA providing post procedure education and counseling, and 20 minutes of an RN/LPN/MA conducting follow-up phone calls back in the office. The panel indicated that additions to the 60 minute G1 post base reflected more complicated services and time required for functions associated with length of stay visits. Any additional time increments were also to be split between an RN and RN/LPN/MA in a 1/3 to 2/3 ratio.

5 The panel indicated that the pre-service functions of the G1 were primarily provided by hospital staff, even when staff accompanied the physician to the hospital.

6 The staff type of surgical assistant is equivalent to RN/CST/CFA (Certified Scrub Tech, or Certified First Assistant) or RNFA or CSTFA.

7 The reference services of several families, had a G0 visit that was a weighted average between 50 % of the time when the service is elective and 50 % of the time when the service is emergent. When the service was typically emergent, the panel indicated that there was not a G0 visit. When the service was typically elective, the panel said that a G0 visit was appropriate and used the times from a reference service with G0 visit that was elective. When the service could either be elective or emergent, the panel used times from a reference service with a G0 visit that represented a weighted average between 50 % of the time when the service was elective and 50 % of the time when the service was emergent.

8 The panel profiled the clinical portion of ZZZ codes, as a stand alone service (equivalent to Hsiao intra time) but indicated that the administrative portion of the service was equivalent to the entire insurance billing portion of the reference service. This time ranged from 45 minutes to 247 minutes. To remain consistent with the profiling of ZZZ codes in other CPEPs, the administrative time was removed from the service and is provided in code level notes in the event HCFA would like to add some or all of the administrative time back to the service.

9 For some 000 and 010 day global period services, the panel included a G0 visit.

Family 364 Orthopaedics - Spine

Family-Level Notes

No family-level notes for family 364

Procedure-Specific Notes

22145	*Reconstruct vertebra(e)*	The panel indicated that the administrative (G2) portion of this service should have 247 minutes of insurance billing time. This time was not incorporated in the data since the service has a ZZZ global period.
22230	*Additional revision of spine*	The panel indicated that the administrative (G2) portion of this service should have 247 minutes of insurance billing time. This time was not incorporated in the data since the service has a ZZZ global period.
22585	*Additional spinal fusion*	The panel indicated that the administrative (G2) portion of this service should have 247 minutes of insurance billing time. This time was not incorporated in the data since the service has a ZZZ global period.
22650	*Additional spinal fusion*	The panel indicated that the administrative (G2) portion of this service should have 247 minutes of insurance billing time. This time was not incorporated in the data since the service has a ZZZ global period.

Family 616 Myelography and Diskography

Family-Level Notes

No family-level notes for family 616

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 616

Family 704 Office Visits - Established Patient

Family-Level Notes

No family-level notes for family 704

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 704

Family 724 Consultation - Inpatient

Family-Level Notes

No family-level notes for family 724

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 724

Family 728 Consultation - Office

Family-Level Notes

No family-level notes for family 728

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 728

Family 1500 Major Procedure - Twist Drill, Burr Hole, Trephine

Family-Level Notes

No family-level notes for family 1500

Procedure-Specific Notes

61106	*Drill skull for exam/surgery*	The panel indicated that the administrative (G2) portion of this service should have 325 minutes (100 minutes - medical secretary, 5 minutes - scheduling secretary, 206 minutes - insurance billing, and 14 minutes - transcription. This time was not incorporated in the data since the service has a ZZZ global period.
61130	*Pierce skull, exam/surgery*	The panel indicated that the administrative (G2) portion of this service should have 325 minutes (100 minutes - medical secretary, 5 minutes - scheduling secretary, 206 minutes - insurance billing, and 14 minutes - transcription. This time was not incorporated in the data since the service has a ZZZ global period.

Family 1504 Major Procedure - Craniectomy or Craniotomy

Family-Level Notes

No family-level notes for family 1504

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1504

Family 1508 Major Procedure - Intracranial Surgery and Skull Procedures

Family-Level Notes

No family-level notes for family 1508

Procedure-Specific Notes

61609	*Transect, artery, sinus*	The panel indicated that the administrative (G2) portion of this service should have 45 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.
61610	*Transect, artery, sinus*	The panel indicated that the administrative (G2) portion of this service should have 45 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.
61611	*Transect, artery, sinus*	The panel indicated that the administrative (G2) portion of this service should have 45 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.
61612	*Transect, artery, sinus*	The panel indicated that the administrative (G2) portion of this service should have 45 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.
61712	*Skull or spine microsurgery*	The panel indicated that the administrative (G2) portion of this service should have 45 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.

Family 1512 Major Procedure - Spine and Spinal Cord

Family-Level Notes

No family-level notes for family 1512

Procedure-Specific Notes

63308	*Removal of vertebral body*	The panel indicated that the administrative (G2) portion of this service should have 284 minutes (85 minutes insurance billing, 5 minutes scheduling secretary, 180 minutes insurance billing, 14 minutes transcription). This time was not incorporated in the data since the service has a ZZZ global period.

Family 1516 Major Procedure - Expior/Decompr/Excis Disc

Family-Level Notes

No family-level notes for family 1516

Procedure-Specific Notes

63035	*Added spinal disk surgery*	The panel indicated that the administrative (G2) portion of this service should have 245 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.
63048	*Removal of spinal lamina*	The panel indicated that the administrative (G2) portion of this service should have 245 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.
63057	*Decompress spinal cord*	The panel indicated that the administrative (G2) portion of this service should have 245 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.

Family 1516 (continued)

63066	*Decompress spinal cord*	The panel indicated that the administrative (G2) portion of this service should have 245 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.
63076	*Neck spine disk surgery*	The panel indicated that the administrative (G2) portion of this service should have 245 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.
63078	*Spine disk surgery, thorax*	The panel indicated that the administrative (G2) portion of this service should have 245 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.
63082	*Removal of vertebral body*	The panel indicated that the administrative (G2) portion of this service should have 245 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.
63086	*Removal of vertebral body*	The panel indicated that the administrative (G2) portion of this service should have 245 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.
63088	*Removal of vertebral body*	The panel indicated that the administrative (G2) portion of this service should have 245 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.
63091	*Removal of vertebral body*	The panel indicated that the administrative (G2) portion of this service should have 245 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.

Family 1520 Major Procedure - Other Nerve

Family-Level Notes

No family-level notes for family 1520

Procedure-Specific Notes

No procedure-specific notes for procedures in Family 1520

Family 1524 Nerve Repair and Destruction

Family-Level Notes

No family-level notes for family 1524

Procedure-Specific Notes

64727	*Internal nerve revision*	The panel indicated that the administrative (G2) portion of this service should have 247 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.
64778	*Added digit nerve surgery*	The panel indicated that the administrative (G2) portion of this service should have 247 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.
64783	*Added limb nerve surgery*	The panel indicated that the administrative (G2) portion of this service should have 247 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.

Family 1524 (continued)

64787 Implant nerve end	The panel indicated that the administrative (G2) portion of this service should have 247 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.
64830 Microrepair of nerve	The panel indicated that the administrative (G2) portion of this service should have 247 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.
64832 Repair additional nerve	The panel indicated that the administrative (G2) portion of this service should have 247 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.
64837 Repair additional nerve	The panel indicated that the administrative (G2) portion of this service should have 247 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.
64859 Additional nerve surgery	The panel indicated that the administrative (G2) portion of this service should have 247 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.
64872 Subsequent repair of nerve	The panel indicated that the administrative (G2) portion of this service should have 247 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.
64874 Repair & revise nerve	The panel indicated that the administrative (G2) portion of this service should have 247 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.
64876 Repair nerve; shorten bone	The panel indicated that the administrative (G2) portion of this service should have 247 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.
64901 Additional nerve graft	The panel indicated that the administrative (G2) portion of this service should have 247 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.
64902 Additional nerve graft	The panel indicated that the administrative (G2) portion of this service should have 247 minutes insurance billing. This time was not incorporated in the data since the service has a ZZZ global period.

Family 1528 Neurostimulator and Ventricular Shunt Implantation

Family-Level Notes

No family-level notes for family 1528

Procedure-Specific Notes

63690 Analysis of neuroreceiver

The panel provided time for a G0 visit when the service is performed out of the office even though this service has a XXX global period. The time and supplies associated with this visit are not incorporated in the data but are detailed below:

G0 - 73 minutes RN/ LPN/ MA

Supplies:

exam table paper	7 ft
pillowcase, disposable	1
patient gown, disposable	1
gloves, non-sterile	2 pair

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Family 1528 (continued)

63691 Analysis of neuroreceiver

The panel provided time for a G0 visit when the service is performed out of the office even though this service has a XXX global period. The time and supplies associated with this visit are not incorporated in the data but are detailed below:

G0 - 73 minutes RN/ LPN/ MA

Supplies:

exam table paper	7 ft
pillowcase, disposable	1
patient gown, disposable	1
gloves, non-sterile	2 pair

Family 1536 Nervous System Injections, Stimulations or Cranial Tap

Family-Level Notes

No family-level notes for family 1536

Procedure-Specific Notes

64612 Destroy nerve, face muscle

Even though this service has a 10 day global period, the panel indicated that there are typically no post-op visits.

64613 Destroy nerve, spine muscle

Even though this service has a 10 day global period, the panel indicated that there are typically no post-op visits.